STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING		COMPI	LETED
		155715	B. WIN			04/13/2	011
		II.	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .			ST CHURCH AVE		
LUTHER	AN COMMUNITY H	IOME INC		1	DUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Recertification and	F0	000	Submission of this Plan of		
	State Licensure S	Survey.			Correction does not constitu		
					admission or agreement by provider of the truth of the fa		
	Survey dates: A	pril 11, 12 and 13, 2011			alleged or corrections set fo		
	· · · · · · · · · · · · · · · · · · ·	,,,			the statement of deficiencies		
	Facility number:	000347			Plan of Correction is prepare		
	-				and submitted because of		
	Provider number				requirements under State a		
	AIM number: 10	002/5440			Federal Law.Please accept		
					plan of correction as our cre	dible	
	Survey team:				allegation of compliance.		
	Marla Potts, RN,	, TC					
	Melinda Lewis R						
	Sharon Whitema						
	Simion Wintellia	, 1					
	Camana land tarre						
	Census bed type:						
	SNF/NF: 103						
	Residential: 27						
	Total: 130						
	Census payor typ	pe:					
	Medicare: 13						
	Medicaid: 53						
	Other: 64						
	Total: 130						
	10tai: 130						
	Sample: 21						
	Residential Samp	ple: 7					
	These deficiencie	es also reflect state					
		dance with 410 IAC 16.2.					
	Quality review 4/19	/11 by Suzanne Williams, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TEEX11

Facility ID:

000347

If continuation sheet

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPL 04/13/2	ETED
	PROVIDER OR SUPPLIER		•	111 WES	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0157 SS=D	resident; consult vand if known, notification representative or a when there is an a resident which respotential for requiring significant changemental, or psychodeterioration in he psychosocial statuconditions or clinical ter treatment significant conditions or clinical ter treatment signification in the psychosocial statuconditions or clinical ter treatment signification in the second second in the second in the facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resident the addresserved in the second in t	is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or ations as specified in					
	review, the factor the physician of a resident's pain, and x-ray fracture, for 1	view and record cility failed to ensure was promptly notified fall, complaints of v results revealing a of 10 residents falls in the sample of	F0	157	F 157 It is the policy of this facility to immediately inform resident; consult with the resident's physician; and if known, notify the resident's leading to the representative or an interested family member when there is accident involving the resident which results in injury and has potential for requiring physicials.	egal ed an nt as the	05/10/2011

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				111 WE	ST CHURCH AVE		
	AN COMMUNITY H	HOME INC		L	OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	21. Resident	#61			intervention; a significant cha in the resident's physical, me		
					or psychosocial status; a nee		
	Findings inclu	ıde:			alter treatment significantly;		
	i mamgs mera	ide.			decision to transfer or discha		
					the resident from the facility.	l.	
	1. Resident #	61's clinical record			Corective Action For The		
	was reviewed	on 4/11/11 at 10:30			Resident Affected: The residual was sent to the hospital, received:		
	A.M.				treatment for the right hip	eiveu	
					fracture, came back to our fa	cility,	
	.	1 4 12/20/11			and received therapy until Ap	oril	
	1	dated 3/29/11 at			22, 2011. Staff members		
	10:45 p.m., in	dicated "Resident			involved in this resident's car	-	
	sitting on floo	r by bed of room (not			were educated that they sho have notified the physician b		
	_	oruising/skin tears. No			telephone of the resident's fa		
		of broken hips can			complaints of pain, and		
	1	•			fracture, rather than faxing th		
	abduct and ad	•			physician's office. A case re		
	without proble	em. No pop/click			of this case was completed in nursing education meetings of		
	heard when m	oving legs, stood			May 4th and 5th, 2011. Gap		
		without problems			communication were identifie		
		esident complains of			and discussed. (Attachment	titled	
		-			Case Review).II. Other Residents Having The Poten	tial	
		Hydrocodone 7.5/500			To Be Affected: All residents		
	given at this ti	me. Updated			requiring physician notification		
	Dr-asked if we	ould like x-ray"			have the potential to be affect	cted.	
		<u>, </u>			The physician notification po		
	The Doct Eall	Reporting Form			was reviewed on April 27, 20)11.	
		Reporting Form			(Attachment titled Physician Notification).III. Systemic		
		29/11 7:00 P.M.			Changes and Steps To Ensu	re	
	resident had a	history of falls,			That The Deficient Practice [Does	
observed on floor in resident's room				Not Recur: Mandatory education			
(not her own), lost				will be held with all nursing s nurses and certified nursing	ιаπ,		
strength/weakness, activity during				assistants, on May 4th and 5	ith,		
the incident was -ambulating in				2011. (Attachment titled			
	me incident w	as -amoulaing in			Required Education for Nurs	ing	

X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Staff). The physician notification bedroom (not her room), getting up policy will be reviewed in detail. It from wheelchair, devices in will be stressed that there are use-chair alarm and anti roll back times when it is appropriate to fax the physician and there are times device, resident's physical status when immediate notification is was weakness and unsteady gait, required, such as for complaints of pain without an order for physician was notified 3/29/11 at medication, an increase in pain 11:00 P.M." that is not controlled, a fall, or a fracture. Staff will also be educated about the plan to LPN #1, on 4/11/11 at 12:15 P.M., prevent any delay in treatment for a resident with a fracture. All provided a fax, dated 3/29/11 at x-ray results will be reviewed by a 10:50 P.M. which indicated "found second nurse to ensure that on floor-sitting by bed. No nothing is missed. Mobilex, our x-ray provider, will notify the bruising/skin tears. No outward director of nursing of all sign of broken hips can abduct and fractures. If unable to reach the director of nursing, the adduct both legs without administrator will be called. Staff problem-No pop or cluck lick heard members were educated about this process in their April staff when moving legs. Stood with meeting and will be again in transfers from floor to wheelchair meetings held May 4th and 5th, 2011. An audit tool was and wheelchair to bed without developed that will be used by the problem with assist. Resident Director of Nursing or her complaints of left leg pain would designee to ensure that physician notification is appropriate and you like x-ray?" timely for all residents who have experienced a fall. (Attachment titled Fall Audit Tool). IV. Fall follow up documentation, Monitoring of Corrective Action: dated 3/30/11 at 5 a.m., indicated Audit results will be reviewed by the Quality Assurance Committee injuries noted-2 bruises on left arm monthly for six months. If the on and near elbow, area of scrape appropriate care and documentation is completed abrasion left upper leg, lateral 100% of the time, monthly aspect near knee, 1 bruise red in monitoring will be stopped and

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE random audits will occur. A color .5 cm above knee, 3 reddish sample size of 25% will be line, 6 cm length 1 cm width area completed monthly. If not open, comments: "resident opportunities for improvement are identified through the random complains of leg pain at 2:55 a.m. audits, a full audit will resume. If complained pain being pretty bad. after six months of random audits, 100% compliance Hydrocodone/ APAP (narcotic pain continues, auditing will stop. The medicine) 7.5/500 one given results of all audits will be reviewed by the Quality effective." Assurance Committee monthly. The Assistant Director of Nursing, on 4/12/11 at 11:00 A.M., provided a fax dated 3/30/11 at 7:30 a.m. sent to the physician which indicated: "right elbow .5 diameter purple bruise right lateral fore arm .5 diameter bruise, right mid thigh lateral aspect 3 red lines, scrape 4 cm by 1 cm no open area, right lateral thigh close to knee small .4 cm diameter purple bruise. Noted 2:45 a.m. gave shower." The physician had responded to the fax at 9:33 a.m. with no new orders. Fall follow up documentation dated 3/30/11 at 12:15 P.M. "question if fracture left lower leg, to request order for x-ray from physician...comments: complains of

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/13/2	LETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO) (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	left groin/left I with slight attermotion left love complains of properties foot in toward for x-ray left I doctorreside with no weight transferring not left lower with new x-ray order. Note that left lower left lower with new x-ray of LLE (left hip, femural left lower left lower with left lower left lower left lower left lower left lower left lower lower left lower lower left lower lower left lower	nip pain, screams out empt with range of wer extremity, pain with flexing left had, to request order ower extremity from int has stayed in bed t bearing or ambulation"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155715	A. BUI	LDING	00	COMPL 04/13/2	
		1557 15	B. WIN	_	DDDEGG GITTY GTATE TIN GODE	04/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC			DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
1710		trolled drug record	+	mo			DATE
	indicated the la	•					
		administered prior to					
	_	30 A.M. was January					
		oo A.M. was January					
	12, 2011.						
	The facility lag	cked evidence of					
	_	d the physician timely					
	_	5/29/11, but having					
		ed office. The facility					
		•					
		ce of having timely					
	notified the ph	·					
		ased complaints of					
	`	medicated for left					
		Hydrocodone ordered					
	for the right hi	p.					
		1 1.4					
		ndicated the x-ray					
		results called to the					
	_	P.M. on 3/30/11.					
		nich included an acute					
	fracture of left	hip with modest					
	displacement	.faxed results to					
	physician"						
	Nurse's notes i	indicated 3/31/11					
	8:30 a.m. "spo	ke with doctoron					
	the phone abou						
	-	eated he would phone					
		n (family member)					
	Laria Speak With						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			,	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155715	B. WIN			04/13/2011
NAME OF I	PROVIDER OR SUPPLIER		•	1	DDRESS, CITY, STATE, ZIP CODE	
LUTHER	AN COMMUNITY H	OME INC		1	ST CHURCH AVE DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		rthopedic surgeon				2.112
	and call back.'					
	indicated an or	rder to send to				
	hospital was o	btained at 10:15 a.m.				
	and the resider	nt transported on				
	3/31/11 at 11:1	15 a.m. The facility				
	lacked evidend	ce of calling the				
	physician and	ensuring he knew of				
	the fracture on	3/30/11 when results				
	were made ava	ailable to the facility,				
	further delayir	ng treatment for the				
	fractured hip.					
	The policy and	l procedure for				
	"Physician No	tification" not dated,				
	obtained from	the Facility				
	Administrator	, on 4/12/11 at 11:50				
	A.M., indicate	ed: "1. If nursing is				
	unable to reacl	h the resident's family				
	physician, the	physician on call for				
	the family phy	sician is notified. If				
	unable to reacl	h the on call				
	physician, the	medical director is				
	notified. 2. Wl	nen notifying a				
	physician of a	resident's				
		that needs prompt				
	attention, state	to the office				
	personnel that	fact. If no response				
	is received wit	thin 2 hours, call the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0250 SS=D	received within physician back the medical direct he does not rest the Director of Administrator communication the resident's resident's resident with social services to a highest practicable psychosocial well-Based on observation record review, the a resident with bowith social service interventions where staff to manage the residents reviewed sample of 21. Reference on the initial tout A.M., LPN # 19 had dementia, and and a recent fraction of the initial tout and a recent fraction.	n is documented in medical record" rovide medically-related attain or maintain the ephysical, mental, and being of each resident. ation, interview and efacility failed to ensure chaviors was provided ees in order to implement ich could be utilized by the behaviors, of 1 of 8 ed for behaviors in the esident #99	F0	250	F 250It is the policy of this fa to provide medically-related services to attain or maintain highest practicable physical, mental, and psychosocial well-being of each resident. I. Corrective Action For Reside Affected: An interdisciplinary team review was completed Resident #99 on April 28, 20 review her care, identify individualized interventions the would avoid the use of unnecessary drugs, and to provide appropriate activities diversion. This individualized care plan was communicated staff through the behavior caplan and through staff educa II. Other Residents Having Totential To Be Affected: All	esocial the ont on	05/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLETED	
		155715	B. WIN			04/13/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
		IOME INO		1	ST CHURCH AVE		
LUTHER	RAN COMMUNITY F	HOME INC		SEYMO	OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	. =	DATE
	bed alarms.		Ī		residents with behaviors hav	e the	
					potential to be affected. An		
	The clinical reco	ord for Resident # 99 was			interdisciplinary team review		
		1/11 at 11:45 A.M. The			completed on all residents w		
					exhibit behaviors on April 28		
		Resident # 99 had			2011. An individualized care		
	diagnoses that in	ncluded but were not			and interventions were devel for residents that can be use		
	limited to demer	ntia and anxiety. The			avoid the use of unnecessary		
	MDS [minimum	data set] assessment,			drugs. These care plans are		
	_	ndicated Resident # 99			available to all staff in a bind		
	1	gnition, and had no			the nurses station.III. Syster	nic	
	1 .	gillion, and had no			Changes and Steps To Ensu	re	
	behaviors.				That The Deficient Practice [Does	
					Not Recur: Behavior care pl		
	The Nurses Note	es, dated 10/20/10 at 7:30			will be discussed and update		
	P.M., indicated '	'Res back at nurses desk			each care plan meeting and		
	with purse in har	nd demanding to talk with			necessary on the nursing un		
	1 ^	es she had spoken with			Behavior care plans will also reviewed in the behavior	be	
	_	inutes earlier and res did			management meetings at lea	ast	
	1 "				every six months and as	201	
		rsation. Stated that she			appropriate. Mandatory		
		ad to come and pick her			education will be held on Ma	y 4th	
	up if (daughter's				and 5th, 2011, with all of the		
	Unsuccessful wi	th 1:1 [one on one] gave i			nurses and certified nursing		
	[one] Ativan (an	tianxiety medication) 0.5			assistants to review this plan		
		for increased anxiety and			correction. (Attachment titled		
	nervousness"	or moreused aminory and			Required Education for Nurs	•	
	nervousiless				Staff). Nurses will be educate that the interventions that are		
		1 . 1 1 0 /02 /10 5 . 00			attempted prior to	5	
		es, dated 10/22/10 at 5:00			medication administration sh	ould	
	1 '	"Awake and at nurses			be documented in the paper		
	station from 11 p	to 3:30 am. Dressed self			medication administration re		
	carrying purse a	round wanting to leave.			An audit tool was developed		
		king to go home, call			used by the Director of Nursi	-	
	1	phew. Redirected without			her designee to ensure that a		
		tivan 0.5 mg at 2:37 am.			individualized interventions a		
		•			behavior care plans are follo		
	Went to bed at 3	.30 A"			prior to the administration of		
	1				medication. (Attachment title	ŧu	

Facility ID:

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	ETED
		155715	B. WIN			04/13/20)11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIEF	8			ST CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME INC		1	DUR, IN47274		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		es, dated 10/22/10 at 6:30			Unnecessary Drugs Audit		
		'PRN [as needed] Ativan			Tool).IV. Monitoring of Corre	ctive	
	· ·	[by mouth] at this time			Action: Audit results will be		
	""	tation. Wanting to go			reviewed by the Quality	alv.	
	·	asking to call family			Assurance Committee montl for six months. If the approp	- 1	
	l -	talk with family."			care and documentation is	, iato	
	even mough did	talk with failing.			completed 100% of the time	,	
	The Newson Net	d-4-d 10/22/10 -4			monthly monitoring will be		
		es, dated 10/22/10 at			stopped and random audits		
	· ·	cated "Resident into			occur. A sample size of 25% be completed monthly. If	o wiii	
		s clothing/pictures and			opportunities for improvement	nt are	
		tems away. Daughter			identified through the randor	n	
	· ·	th res first then talked			audits, a full audit will resum		
		ghter requested that			after six months of audits, 10		
	`	ame) to see if res could			compliance continues, auditi will stop. The results of all a	- 1	
	get something el	se referring to			will be reviewed by the Qual		
	medication. Wri	ter called on call Dr			Assurance Committee montl		
	(name). Gave or	der for Haloperidol					
	(antipsychotic m	edication) 5mg/ml Give					
	1/2 (2.5 mg) IM	[intramuscular] for					
	agitation. Gave l	IM in L [left]					
	ventrogluteal wi	th compliance from					
		giving medication/IM					
		ip laminated copy of					
		el that was roommate's.					
	Writer took away						
		<i>,</i>					
	The Nurses Note	es, dated 10/23/10 at 6:45					
		'Res anxious and					
	ĺ	en but not effective in					
	calming."	on but not effective in					
	canning.						
	The Nurses Note	es, dated 10/23/10 at 7:00					
		'Gave Ativan 0.5 mg for					
	anxiety"						

000347

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715			(X2) MULTIF A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED
	PROVIDER OR SUPPLIE		ST1	1 WES	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	P.M., indicated recliner to room telephone book dau [daughter], getcunsuccessfusessions. Repetitinervous behavior por for anxiety	es, dated 10/24/10 at cated "Res anxious and g redirection yelling at o go home wanting dau to r. Interrupting report, recliner. MD notified aldol (antipsychotic g/ml give 2.5 mg IM for flay give 2.5 mg in 4 hours us and agitated." es, dated 10/25/10 at feated "Gave Haldol 2.5 PMContinues to be					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155715	A. BUI		00	04/13/2011	
		100710	B. WIN		DDDEGG CITY GTATE ZID CODE	04/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATI	E.
		tation Yelling wanting to					
	~	ntion codes- redirect, 1					
		food, give fluids, call					
	daughter."						
	The Nurses Note	s, dated 10/27/10 at 4:30					
		'Res awake at 11:15 PM					
	· ·	and others rooms going					
		belongings. Packing					
		around. Attempting to get					
		to go home. Tried to					
	ľ	down in bed, recliner.					
	I -	beanut butter and jelly]					
		es) milk consumed both					
	`	edirected in others rooms					
	and asking to lea	ve. Gave Ativan 0.5 mg					
	po at 1:39 AM'	1					
	The Nurses Note	s, no date or time,					
		10/27/10 5:40 P.M. note					
	`	00 A.M. note), indicated					
		to sleep. In and out of					
	bed in and out of	room. Unable to be					
	redirected d/t [du	e to] increased anxiety.					
	Asked nurse for	cup of water then stated					
	Is the medicine in	n here? Res then said the					
	medicine helps h	er sleep. Gave Ativan 0.5					
	mg at 12:40 AM.	"					
	The Nurses Note	s, dated 10/28/10 at 2:15					
		Daughter in to visit					
		rnoon. Noticed that					
		be oversedated from					
	Ativan. Requeste	ed that Ativan be					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155715	B. WIN			04/13/2011
NAME OF I	DROVIDED OD GUDDI IED		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	PROVIDER OR SUPPLIER			111 WE	ST CHURCH AVE	
	AN COMMUNITY H				OUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DETICIENC!)	DATE
	decreased to only					
	1	RN. Called (name) at Dr				
		d made aware of family				
	request. N.O. [ne	-				
	1	AM dose of Ativan 0.5 mg				
		Continue HS dose and				
	_	es at q [every] 6 hours as				
	needed for anxie	ty"				
	The Nurses Note	es, dated 10/28/10 at				
		cated "Res up in room				
		ommate's belongings				
	1	vere hers. 1:1 provided				
		CNAs also trying to				
		n no success. Res wants				
	_	ughter (name) insisting				
	1	nd picking up resident.				
	Res given routine	e Ativan at 8 pm"				
	The Nurses Note	es, dated 10/29/10 at 1:00				
	A.M., indicated '	'Awake wandering halls				
		s into roommates				
	belongings in dra	awers. Very anxious at				
		hange past several nights.				
		(sic) her belongings				
	1	to go home wants staff to				
	1	to pick her up. Res at				
	_	d med carts demanding to				
		belongings. Attempt to				
	1 "	by offering food fluid				
		search 1:1. None of these				
	_					
	interventions have been successful this					
		mg po at 11:47 PM for				
	anxiety/agitation	"				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 04/13 /2	LETED	
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	12:50 A.M., indihighly agitated redown hallway erroomsResd good clothes out in harooms. Very anx Ativan 0.5 mg is anxiety/agitation. The Nurses Note A.M., indicated roommate's cloth would not go to upsetting roommanxious/agitation at present refuse. CNA one on one present to help wupset as well." The Nurses Note A.M., indicated in trash can, hers Coming to hall a up papers any ite glasses books. H [breakfast] movi Unable to redired grandpa and my monitor."	Ing through roommate's allway and back to other ious becoming upset. It is given for increased at the second of the second of the second of the room at the still very at contunable to redirect as to come to nurses desk with resd in room at the roommate being and roommate being and roommate's. In and nurse's desk packing the second of the room at the roommate being and roommate's. In and nurse's desk packing the second of the room at the roommate's are the second of the roommate's. In and nurse's desk packing the second of the roommate's are the second of the roommate's. In and nurse's desk packing the second of the roommate's are the second of the roommate's. In an all the roommate's are the second of the roommate's are the second of the roommate's. In all the roommate's are the second of the roommate's are the se					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	155715		A. BUI	LDING	00	04/13/2011	
		1507 10	B. WIN		DDDDGG GITH GTATE ZID GODE	04/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC			OUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE	
	A.M., indicated "Continues nonstop with above behavior have tried above distractions but res not re-directed. Ativan 0.5 mg po given at this time."						
	0.5 mg po given	at this time."					
	The Behavior/Int	tervention Monthly Flow					
	Record, dated No	ovember 2010, indicated					
	"Behavior 1. A. a	agitation B. yelling C.					
	wanting to go ho	me. Intervention codes-					
	redirect. 1 on 1, r	refer to nurses notes,					
	activity, return to	room, toilet, give food,					
	give fluids, chang	ge position, adjust room					
		k rub, call family, give					
	PRN Ativan, give	e PRN Haldol."					
	The Nurses Note	s, dated 11/1/10 at 12:10					
	A.M., indicated '	'Awake and at nurses					
	station at 11 PM.	Interrupting during					
	report. Continues	s with constant questions.					
	Intrusive, looking	g through papers, folders,					
	lab book, getting	into cups and med cups					
	in med cart. Was	trying to touch med					
	cards. Was consta	antly redirected, 1:1,					
	offered food and	fluid assisted with					
		as. Wanting to call her					
		Found res at door to					
	-	light on above door.					
		cked. Was also walking					
	-	er room, entered res room					
	across hall."						
	The Nurses Note	s, dated 11/1/10 at 3:40					
		'Gave Ativan 0.5 mg at					
	3:03 AM"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE		
AND PLAN	155715		- 1	LDING	00	04/13/20 ⁻	
		100710	B. WIN		DDDEGG CITY CTATE ZIR CODE	04/10/20	''
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC			OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Nurses Note	s, dated 11/1/10 at 6:30					
		Res walks up and down					
	· ·	into other resident's room					
	and going throug						
	and going unoug	ii tiicii itciiis.					
	The Nurses Note	s, dated 11/2/10 at 5:30					
	A.M., indicated '	'Res anxious, agitated,					
	intrusive, unredir	rectrable (sic). At nurses					
	station until 2:30	AM gave Ativan 0.5 mg					
	i at 12:20 AM, in	effective. Continued to					
	be anxious, refus	ed to sit or lie in recliner					
	or bed. Rummag	ing in papers at nurses					
	station. In bed at	2:30 AM had remained					
	in bed since 2:30	AM."					
		s, dated 11/3/10 at 8:45					
		'Res up to nurses desk					
		es]. I've got to go home.					
	_	s appt [appointment]					
		ket book? Where are my					
	•	go home. 1:1 [one to					
	_	ch calmed res some but					
		vorried about needing to					
		o [complains of] L [left]					
		t. PRN [as needed]					
	Tylenol and Ativ	an given at this x."					
	The Nurses Note	s, dated 11/5/10 at 6:50					
	· · · · · · · · · · · · · · · · · · ·	'Res has been intrusive					
		n into all but 2 resident's					
		t. Unredirectable (sic)					
		ventions which were					
	ineffective. Gave	Ativan 0.5 mg i [one] po					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF 1	PROVIDER OR SUPPLIEF	₹		1	ST CHURCH AVE		
LUTHER	RAN COMMUNITY H	HOME INC		1	OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	17 AM was ineffective.					
	Continued to go	into rooms when					
	residents were sl	eeping. Awakened					
	several residents	attempting to take res's					
	belongings some	e res became upset					
	" "	this resident. Intervened					
	1 ^	ok res out of room. Was					
		y house this is my room I					
	1 ' '	I want. This behavior					
	1 ~	shift res did not sleep					
	1	Dayshift nurses notified of					
	1 ^	•					
	1	ON [Director of Nursing]					
	notified. Continu						
	wandering in res	s rooms."					
	The Nurses Note	es, dated 11/5/10 at 2:30					
	P.M., indicated '	'Awake all day active in					
	and out of reside	ent's rooms taking others					
	1	their rooms eventually					
	1	back. Res has been up in					
		gathering items to go					
	home"	gathering items to go					
	inomic						
	The Nurses Note	es, dated 11/6/10 at 6:30					
		'Res up at this time.					
	1	s is her home and wants					
	1	organized her house.					
	Upset that walkers in lounge by respective						
	residents who need these walkers. This						
	resident tried to move but staff redirected."						
	The Nurses Note	es, dated 11/6/10 at 7:05					
	P.M., indicated '	'Res going in and out of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
AND PLAN	155715		A. BUI	LDING	00	04/13/20	
		1557 15	B. WIN			04/13/20	, , , ,
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274		
		TATEMENT OF DEFICIENCIES	-				(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	other resident's re	oom. making beds and					
	going through closets/dressers. Very						
	1 0 0	off try to redirect. Res					
	1 ~	states Get out of my					
		oral meds [medications]					
		nipin (sic) and Depakote.					
		ven IM R [right] ventral					
	gluteus."						
	The Nurses Note	s, dated 11/8/10 at 3:00					
	A.M., indicated '	'Res sitting in recliner at					
		get out and go home.					
	Asked to sit seve	ral times, clip alarm					
	sounding said sh	e had to get home. Spent					
	I -	ed with folding clothes,					
	food, fluid, readi	_					
		tinued 1:1 with res. In					
	hallway, draggin	g blankets, purse and					
		tempting to go into res					
	rooms. Yelling at	t staff awaking (sic)					
	1	ns. Ref [refused] to sit or					
		Attempted to give Ativan					
		sed. Gave Haldol 2.5 mg					
		ar] in L [left] buttocks at					
	_	ole to sit in recliner at					
	1:30 AM"						
	The Nurses Note	s, dated 11/9/10 at 5:30					
	P.M., indicated "	At nurses station					
	asking for her pu	rse. Asking repetitive					
	questions per usu	ial. Speaking with slow					
	somewhat slurred	d speech. Insisting she is					
	not staying here	tonight. Staff attempting					
	to redirect or re-o	orient without success.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC (X4) ID PRETX TAG SIMMARY SYSTEMAN OF DEPICEDCUS (EACH DEPICIENCY MUST BE PERCEDED BY PULL REGULATORY OR US: IDENTIFYING PROBABION) (EACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR US: IDENTIFYING PROBABION) (EACH DEPICIENCY OF COMMUNITY HOME INC COMPLETION DATE (X5) PRETX TAG (X6) PRETX TAG (X7) PRETX TAG (EACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR US: IDENTIFYING PROBABION) TAG (X7) TAG (X8) PRETX TAG (X8) PRETX TAG (X8) PRETX TAG (X8) COMPLETION DATE (X9) COMPLETION DATE (X8) COMPLETION DATE (X8) COMPLETION DATE (X9) COMPLETION DATE TAG (X9) COMPLETOR TAG TAG (X9) COMPLETION TAG TAG TAG TAG TAG TAG TAG TA	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE : COMPL	ETED	
LUTHERAN COMMUNITY HOME INC (X9) ID SUMMARY STATEMENT OF DETICIENCES PREEIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) Will continue to re-direct or re-orient to current living conditions. Staff cannot convince resident that family is aware. Will cont [continue] to monitor for any changes." The Nurses Notes, dated 11/9/10 at 8:30 P.M., indicated "Resident in recliner with foot rest extended up. Res previously toileted, walked in bedroom and hallway, and changed into night gown. Continuously asking to call parents and siblings. Res thinks she is going home / going to church function. Res states she doesn't have a car to drive. Res tries to get out of recliner with foot rese extended. Staff asks what needs are and res states I'm going home. Staff reminds resident that she has a bed here to sleep in. Writer helped resident to get back in recliner when resident stated I will kick you in the guts. Aide then got kicked in stomach by this resident. Resident that family comes in to see resident regularly and they know she's here. Another staff member stated that the doctor has authority to release this resident.			155715	- 1			04/13/2	011
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SUMMARY STATEMENT OF DEPICIENCES TAG	LUTUED	A N.I. COOR AR ALLIN LITTLY I	IONE INO					
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Will continue to re-direct or re-orient to current living conditions. Staff cannot convince resident that family is aware. Will cont [continue] to monitor for any changes." The Nurses Notes, dated 11/9/10 at 8:30 P.M., indicated "Resident in recliner with foot rest extended up. Res previously toileted, walked in bedroom and hallway, and changed into night gown. Continuously asking to call parents and siblings. Res thinks she is going home / going to church function. Res states she doesn't have a car to drive. Res tries to get out of recliner with foot res extended. Staff asks what needs are and res states I'm going home. Staff reminds resident that she has a bed here to sleep in. Writer helped resident get situated better in recliner and res kicked writer. Soon after an aide helped resident to get back in recliner when resident to get back in recliner when resident stated I will kick you in the guts. Aide then got kicked in stomach by this resident. Resident kicked with much force with both legs/feet. Staff tried to redirect/reassure resident that family comes in to see resident tegularly and they know she's here. Another staff member stated that the doctor has authority to release this resident. Resident & authority to release this resident.						JUR, IN47274		
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convince resident that family is aware. Will cont [continue] to monitor for any changes." The Nurses Notes, dated 11/9/10 at 8:30 P.M., indicated "Resident in recliner with foot rest extended up. Res previously toileted, walked in bedroom and hallway, and changed into night gown. Continuously asking to call parents and siblings. Res thinks she is going home / going to church function. Res states she doesn't have a car to drive. Res tries to get out of recliner with foot res extended. Staff asks what needs are and res states I'm going home. Staff reminds resident that she has a bed here to sleep in. Writer helped resident get situated better in recliner and res kicked writer. Soon after an aide helped resident to get back in recliner when resident stated I will kick you in the guts. Aide then got kicked in stomach by this resident. Resident kicked with much force with both legs/feet. Staff tried to redirect/reassure resident that family comes in to see resident regularly and they know she's here. Another staff member stated that the doctor has authority to release this resident. Resident								
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authority to release this resident. Resident		I -						
stated s on the doctor."		1						
		stated s on the	e doctor."					
The Nurses Notes, dated 11/19/10 at 9:20		The Nurses Note	es, dated 11/19/10 at 9:20					
The Nurses Notes, dated 11/19/10 at 9:20		The Nurses Net	as dated 11/10/10 at 0.20					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155715	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIE	R.			ADDRESS, CITY, STATE, ZIP CODE		
				1	ST CHURCH AVE		
LUTHER	RAN COMMUNITY F	HOME INC		SEYMO	DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	•	"Walking up/down		IAG			DAIL
	· ·	• .					
	hallways. In/out of other resident's rooms. Not sleeping this shift. Tried to push on						
		oors to try to go out to car.					
		ng items to go home. Staff					
		t that her family has paid					
		oend night here. Staff					
	1	t that we are here to help					
	resident"	•					
	The Nurses Note	es, dated 11/26/10 at 2:10					
	P.M., indicated	"Pharmacists made					
	recommend (sic) after behav [behavior]					
	committee met a	and discussed res sleeping					
	1	being awake at noc					
	[night]. She freq	[frequently] disrupts					
	1	t noc and isn't easily					
	re-directed. Spo	*					
		suggested Melatonin 3					
		to help realign her					
		He said studies have					
	_	ults when someone has to					
	1	les to adjust "clinically					
		no SE [side effects] or					
		his has been discussed at					
	length for this re						
		obility. Spoke with					
		re: above, she said she's d her we will monitor res.					
		ne) waiting response."					
	Opuated Di (nai	ne) waning response.					
	The Rehavior/In	ntervention Monthly Flow					
		ecember 2010, indicated					
		itation, yelling, wanting to					
	Denavior 1- ag	itation, yennig, wanting to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIEF		•	111 WE	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE OUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	on 1, refer to nur to room, toilet, go change position, back rub, call far refer to nurses nor room, toilet, give change position, back rub, call far clean, organize, help if necessary meds. Intervention 1, refer to nurses room, toilet, give change position, back rub, call far The Nurses Note P.M., indicated sitting on trash com, voiding in redirected reside. The Nurses Note P.M., indicated shift resident was west end exit do (number) resider for an opportunity resup at 5 AM. (number) resider of scarves from tyelled at (number)	ention codes- redirect. 1 rses notes, activity, return rive food, give fluids, adjust room temperature, mily, redirect. 1 on 1, rotes, activity, return to refood, give fluids, adjust room temperature, mily, have her sweep, ask family to come in to refood, give fluids, adjust room temperature, mily, have her sweep, ask family to come in to refood, give fluids, redirect. 1 on refood, give fluids, adjust room temperature, mily, come/go back later." res, dated 12/2/10 at 6:30 reform temperature, mily, come/go back later." res, dated 12/2/10 at 6:30 res, dated 12/11/10 at 2:10 res, date					

000347

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) MU A. BUILI B. WING	DING	nstruction 00	(X3) DATE S COMPL 04/13/2	ETED
	PROVIDER OR SUPPLIER		p. wate	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	that (number) ca	Explained to resident nnot help it. Resident nding once explained to					
	P.M., indicated ' Has been in othe their things. Has	es, dated 12/11/10 at 1:30 l'Has been awake all shift. ers rooms but didn't bother collected a pillowcase of arried it on the unit. Swept th other res"					
	11:15 P.M., indicords between we lounge area. Attouristic concerned on cords and fall let cords alone. I leave me alone I window. Residen	es, dated 12/11/10 at cated "Res inspecting vall and recliners in empting to unplug cords. d that resident might trip I. Writer asked resident to Res stated If you don't 'Il throw you out that int finally left cords alone mes of asking to leave					
	10:00 P.M., indi area getting behi trying to unplug recliners. Very h insistent on unpl cords. Daughter distract her with	es, dated 12/14/10 at cated "Resident in lounge and recliners next to wall TV, Christmas tree et ard to redirect was ugging the electrical (name) called to help success."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIER	ę.		111 WE	ST CHURCH AVE		
	AN COMMUNITY H				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL				ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILIACI)		DATE
	· ·	"Awake since 11 PM Into					
		ooms multiple times.					
	1 20 0	ts to Christmas tree.					
	_	ts off tree. Staff redirects					
		Tore off garland off					
	nurses desk and	took to personal room."					
	The Nurses Note	es, dated 12/31/10 at 6:00					
	P.M., indicated '	'Called dtr [daughter] to					
		[patient] very anxious and					
	1	y out. Gave prn [as					
	needed] Ativan.'						
	The Behavior/In	tervention Monthly Flow					
		nuary 2011, indicated					
	· ·	tation, yelling, wanting to					
	_	ention codes- redirect. 1					
	-	rses notes, activity, return					
		give food, give fluids,					
	1	adjust room temperature,					
		mily, have redirect. 1 on					
		s notes, activity, return to					
	· ·	•					
	1 '	e food, give fluids,					
	1 0 1	adjust room temperature,					
	· · · · · · · · · · · · · · · · · · ·	mily, have her sweep,					
	1	ask family to come in.					
		using meds. Intervention					
		1 on 1, refer to nurses					
	1	eturn to room, toilet, give					
	food, give fluids	, change position, adjust					
	room temperatur	e, back rub, call family,					
	come/go back la	ter."					
	The Nurses Note	es, dated 1/7/11 at 3:30					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	walked toward and and threw res charand attempted to across threshold redirect when rest to turn off hall lighthat I want these paying for these pocketbook. Also res by grabbing I my pajamas, get redirected res we and closed eyes.' The Nurses Note A.M., indicated television. Redirected to roo resident if wanter clean. PRN [as no given at this time. The Nurses Note A.M., indicated wanting around the wanting around the wanting ankle room wanting her sisted thave tried to red folding laundry endirected to red fo	o tried to shake another her arm, stating those are them off now. CNA's not to recliner sat down as, dated 1/9/11 at 1:15 (Up/down. Unplugging ection, 1:1 ineffective. Laids x [times] 1. form (number) asking doto clean. Refused to deeded] Ativan 0.5 mg as. Did accept in pudding." Is, dated 1/10/11 at 8:43 (Awake all morning anit looking for glasses. The arm alert bracelet cut off. For so she can cut it off. irect with sweeping					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIEF			111 WE	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	P.M., indicated 'others rooms pilirooms and placin res that she was other's rooms and thief. Told her the understood that stimes. Redirected replaced items to times. Redirected replaced items to the Nurses Note A.M., indicated halls and into othe Redirected offer refused. Poured sat on table for refused. Poured sat on table for rewhen attempting staff and residen now or I'm going behind recliners out of wall for T screen. Continue to res door and to door. Asked to c refused and yelled looked at flower 1/2 hour, gave A mouth] at 2:06 A. The Nurses Note P.M., indicated '	es, dated 1/11/11 at 4:20 'Res up wandering in fering items from others ag in her room. Advised not to take things from d res stated she was not a lat I knew she wasn't but I she gets confused at d res to her own room and aken from other's rooms." es, dated 1/13/11 at 4:00 "Res awake, wandering in her's rooms at 11:15 P.M ed food and fluids a cup of apple juice and es. Behavior escalated at to get out of my house g to call the police. Went and pulled electrical cord V. Tried to push on TV and to yell at CNAs. Went ried to pull wreath off ome back to recliners, ed. Sat with res and and seed magazine for tivan 0.5 i [one] po [by AM." es, dated 1/13/11 at 9:00 'Standing on chair trying of as curtains where blinds					

000347

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE :	ETED	
		155715	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN COMMUNITY F	HOME INC			ST CHURCH AVE DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ring lounge. Staff got res					
	1	ced chair in different					
		being pulled down by this					
	1	ying to give resident					
		to this resident but					
	1	hat staff members are					
	1	dent loss (sic) appetite.					
		hair and began hanging					
		nds are. Chair taken by					
		tempted to call (grandson					
		one but not good					
	connection. Called daughter earlier in						
		nfection (daughter's					
	name) is sick an	d will let her rest per her					
	request. Has gra	bbed at clothing of staff					
	taking away cha	ir. Res stated I will pound					
	your head and I	will knock the s out of					
	you."						
	A Social Service	es Notes, dated 1/27/11,					
	no time, indicate	ed "Social Services spoke					
	with Behavior m	ngmt [management]					
		arding resident's anger,					
	1	rbal out burst. Dr (name)					
	~	by nursing staff. Social					
		ntinue to support and					
	assist PRN [as n						
		1.					
	A Behavior Man	agement Team Review,					
	dated 1/27/11 no	•					
		behavioral occurrences.					
		of occurrences in the past					
		e causes, medical					
	considerations, p						
	L considerations, I	noorprouning und					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155715	A. BUI		00	04/13/2	
		1007.10	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 17 10/2	
NAME OF I	PROVIDER OR SUPPLIER			1	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ors (if known). Review					
	1 ^ *	dications to include					
		ses and any side effects					
	noted. Document						
		sSummary- Behaviors					
		r, agitation, bossyness					
	(sic), verbal aggr						
	`	erventions): almost daily.					
	Precipitating Fac						
	1 1	dication and Care:					
	_	at 6p, lorazapam 0.5					
	PRN. Recommendation: Refer all to						
	'	name), possible med					
	-	nge, mini mental					
	assessment to de	termine type of					
	dementia."						
	The Nurses Note	s, dated 1/27/11 at 12:00					
	P.M., indicated "	Behav [behavior] mgmt					
	[management] te	am met re: res increased					
	behav and becom	ning more difficult to					
	re-direct. Has use	ed Ativan 6 x [times] past					
	mo [month]. Rec	ommend (Psych					
	company name)	consult since Dr (name)					
	is back from sick	leave. Dr (name) seen					
	res while Dr (nar	ne) was out. Updated Dr					
	(name) on this ar	nd asked if he's still ok					
	with (Psych com	pany name) seeing res.					
	(Daughter name)	states is fine with her."					
	The Nurses Note	s, dated 1/27/11 at 1:40					
	P.M., indicated "	At desk past hour asking					
	for phone to call	(daughter name) near					
	tears have tried 1	:1 [one to one] offered					

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Event ID: **TEEX11** Facility ID:

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	LETED
		155715	B. WIN			04/13/2	2011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	K		111 WE	ST CHURCH AVE		
	RAN COMMUNITY I				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		, magazine and office					
	1	g more upset. Call placed					
	1 ` •	ne) she spoke with res 5					
	1	. (Daughter name) spoke					
	1	uested I give her Ativan.					
	Gave 0.5 mg at	this time."					
	The Nurses Not	es, dated 1/27/11 at 7:00					
	P.M., indicated	"Res going into other					
	resident's rooms	and rearranging					
	regarding to resident's own wishes. Res						
	becomes upsets (sic) when staff tries to						
	redirect. Has refused 6 pm Klonopin x						
	[times] 2. Asked resident if wanted to						
	1	or (grandson name) (sic).					
	1 ' -	No x 2. Res redirected to					
	_	lean but resident refused					
	_	of dining room and					
		n wing hallway tearing					
		orations off doors and					
	walls."	orations off doors and					
	waiis.						
	The Nurses Not	es, dated 1/27/11 at 7:20					
		"This res walking along					
	1	ident who was holding a					
		ip. This beverage spilt					
	1	r. Witnessed by 2 staff					
	1 ` ′	lent denied hitting cup of					
		nt. (Daughter name) was					
		d to come in and help					
	resident calm do	•					
	resident cann de	J γγ 11.					
	The Debayier/Ir	ntargantian Manthly Flagg					
	1	ntervention Monthly Flow					
	Record, dated F	ebruary 2011, indicated					

NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH LATORY OR LSC IDENTIFYING INFORMATION) "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later." The Nurses Notes, dated 2/6/11 at 8:04 A.M., indicated "Res up before 7 A shift.		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MU A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPL 04/13/2	ETED
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Has been going to other res asking why are you in my house! Who gave you permission? Pointing her finger in their face. Banging fist on desk. Explain why all these people are in my house? Tried talking 1:1 [one to one] with res. refused Bfast [breakfast] offered to dust furniture, wipe tables etc No! I want an answer. Gave Ativan 0.5 mg at this time." The Social Services Note, dated 2/6/11 no time, indicated "Dr (name) was here today to see resident. No new orders were written. Social Services will continue to support and assist PRN." The Social Services Note, dated 2/11/11 no time, indicated "Social Services		go home. Interve on 1, refer to nur to room, toilet, ge change position, back rub, call faclean, organize, Behavior 2- Refeodes- redirect. notes, activity, refood, give fluids room temperatur come/go back later to the Nurses Note A.M., indicated Has been going are you in my he permission? Point face. Banging finall these people talking 1:1 [one Bfast [breakfast] wipe tables etc. Gave Ativan 0.5] The Social Servettime, indicated to see resident. It written. Social Support and assistance of the social Servettime and the social Servettime and the social Servettime and assistance of the social Servettime and the social Servettime and assistance of the social Servettime and the social Servetti	ention codes- redirect. 1 rses notes, activity, return give food, give fluids, adjust room temperature, mily, have her sweep, ask family to come in. fusing meds. Intervention 1 on 1, refer to nurses eturn to room, toilet, give s, change position, adjust re, back rub, call family, ster." es, dated 2/6/11 at 8:04 "Res up before 7 A shift. to other res asking why buse! Who gave you nting her finger in their st on desk. Explain why are in my house? Tried to one] with res. refused offered to dust furniture, No! I want an answer. I mg at this time." ices Note, dated 2/6/11 no 'Dr (name) was here today No new orders were fervices will continue to st PRN."					

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Event ID: TEEX11 Facility ID:

000347

If continuation sheet

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The Nurses Notes, dated 2/11/11 at 6:25 P.M., indicated "Called grandson (name)		l -	g [message] on					
P.M., indicated "Called grandson (name)		voiceman.						
		The Nurses Note	es, dated 2/11/11 at 6:25					
		P.M., indicated '	'Called grandson (name)					
et told him that staff has poisoned her								
food, et that she will not take her								
medicine because we are trying to poison		medicine becaus	e we are trying to poison					
her was upset with staff for calling gr son		her was upset wi	th staff for calling gr son					
(name) d/t [due to] she didn't want to		_						
wake him up. Staff reported that resident		wake him up. St	aff reported that resident					
hit at staff member twice. Resident occas								
[occasionally] pursing lips et breathing		[occasionally] pr	ursing lips et breathing					
out with force. Grandson (name) stated		out with force. C	Grandson (name) stated					
that he will meet staff at chapel door in 3		that he will meet	t staff at chapel door in 3					
minutes et that staff needs to bring		minutes et that s	taff needs to bring					
resident's medicine to him so resident will								
not know that we gave it to him et he will		not know that w	e gave it to him et he will					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155715	A. BUII		00	04/13/2011
		1007 10	B. WIN		DDDEGG CITY CTATE ZINCODE	04/10/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE	
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	' "	nt her medicine to do so.				
		one on one] et keeping				
		om other residents as				
	much as possible	when needed."				
	The Social Servi	ces Progress Notes, dated				
		indicated "Social				
		d a referral form on				
	2/14/11. Social S	ervice form stated res				
	likes to be a motl	her hen wants to take care				
	of others. Puts ex	cessive blankets on other				
	residents. If anot	her resident doesn't want				
	to eat, (Resident	# 99) will give				
	food/fluids to oth	ner residents. When staff				
	redirects, (Reside	ent # 99) becomes upset.				
	l ` ′	eels like her good				
		ing misinterpreted as bad				
	1 ^	cial Services spoke with				
	nursing staff will	-				
	-	management] program to				
	be evaluated. So					
	continue to suppo	ort and assist."				
	In an interview w	vith the Social Services				
	Director, on 4/13	/11 at 8:30 A.M., she				
	indicated this wa	s the first time social				
	services had addı	ressed the behaviors.				
	The Nurses Note	s, dated 2/15/11 at 4:00				
		'Resting in recliner at				
		been up the past 45 mins				
	_	all electrical devices et				
	[and] in and out i					
	redirected."	tooms not casily				
	Touricotcu.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **TEEX11** Facility ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S	ETED
		155715	B. WIN	G		04/13/20	011
	PROVIDER OR SUPPLIER AN COMMUNITY H			111 WE	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	- ,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	Record, dated Ma "Behavior 1- yel home. Interventic 1, refer to nurses room, toilet, give change position, back rub, call fan organize, clean. I meds. Interventic 1, refer to nurses room, toilet, give change position, back rub, call fan The Nurses Note P.M., indicated " chair taken to bat success. Confuse this time." The Nurses Note A.M., indicated " Looking for her r is she? Have give coffee. Ambul (s Looked at remine Gave her phone to look up phone #. [continue] to be r	mom and phone #. Where en bfast [breakfast] and ic) in hall with staff. ece (sic) book with her. book, paper and pen to					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SUF COMPLETI 04/13/201	ED
	PROVIDER OR SUPPLIED		p. was	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
				<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	(X5) COMPLETION DATE
_		es, dated 3/7/11 at 8:15		-			
		"Res wants to call mom					
	1 '	es worried that a little girl					
		Staff reassures that no					
		been taken. Res has been					
	_	ning. Res has been folding					
	1 -	s been taken to restroom.					
		s offered but resident					
	_	book given to resident					
		ivan given at this time."					
	10011 41. 114 (114	ivan given at time time.					
	The Nurses Note	es, dated 3/9/11 at 6:30					
	P.M., indicated "Resident up and down in						
		to ambulate with					
		ecame restless, agitated.					
	, , ,	d fluids- refused. Offered					
		was accepted but res still					
	1 -	e anxious wanting to go					
		sister and brother (all					
	_	l and shaky. Gave i [one]					
		o at this time. Will					
	monitor effectiv						
		···					
	The Nurses Note	es, dated 3/14/11 at 6:00					
		"Fall risk continues. Was					
	1 '	ixious, shaking and unable					
	1	fusing food and fluids.					
		mg i po at 3:06 AM, eff					
	[effective]"						
	The Social Serv	ices Note, dated 3/14/11					
		ed "Social Services					
	· ·	dents lethargy. Dr (name)					
		ocial Services will					
		· · · · · · · · · · · · · · · · · · ·		!			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER					INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
1111212111	or conditions	155715	A. BUI			04/13/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	ST CHURCH AVE	
LUTHER	AN COMMUNITY H	OME INC		SEYMO	DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		ort and assist PRN."		IAG		DATE
	continue to suppo	ort and assist I Kiv.				
	The Nurses Note	s, dated 3/16/11 at 3:30				
		Faxed Dr. (name) the				
	· ·	sident has an order for				
	ı	oo q [every] 2 hours prn				
		e than 1.0 mg in 24 hours.				
	~) would like order				
	· · ·	mg po q 2 hours prn				
	agitation- not mo	ore than 0.5 mg in 24				
	hours due to caus	ses over sedation for				
	many hours/shift	s. Spoke with dau (name)				
	this AM over pho	one."				
		1 - 10/17/11 - 10 40				
		s, dated 3/17/11 at 10:40				
	· ·	'NO [new order] per Dr				
	_ `	scontinue] Ativan 0.5				
		to 0.25 mg po q 2 hours				
	_	n not more than 0.5 mg in				
	hrs/shifts"	sedation for many				
	1115/5111115					
	The Social Service	ces Note, dated 3/24/11				
		d "Dr (name) in today to				
	· · · · · · · · · · · · · · · · · · ·	Resident # 99) regarding				
	her progress. Soc	, ,				
		ort and assist PRN."				
	The Behavior/Int	ervention Monthly Flow				
	Record, dated Ap	oril 2011, indicated				
	· ·	lling, wanting to go				
	home. Intervention	on codes- redirect. 1 on				
	1, refer to nurses	notes, activity, return to				
	room, toilet, give	e food, give fluids,				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
NAME OF	DDOVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	X		111 WE	ST CHURCH AVE		
LUTHER	RAN COMMUNITY F	HOME INC		SEYMO	DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DLI ICLLACT)		DATE
		adjust room temperature,					
	I	mily, have her sweep and					
		2- Refusing meds.					
	1	les- redirect. 1 on 1, refer					
	1	activity, return to room,					
	1 '	give fluids, change					
	1 * * *	room temperature, back					
	rub, call family,	leave and try later."					
	l						
		irector of Nursing					
	1 -	vior Intervention Detail					
	Report, on 4/13/11 at 8:15 A.M. The						
	1 ^	ehaviors exhibited by					
	Resident # 99 sii	nce October 2010. The					
	form indicated f	rom 10/15 to 10/30/10,					
	Resident # 99 ha	nd 17 behaviors in which					
	staff attempted 3	37 interventions with 7 of					
	those being effect	ctive, from 11/1 to					
	11/30/10 Reside	nt # 99 had 38 behaviors					
	in which staff at	tempted 89 interventions					
	with 8 of those b	peing effective, from 12/2					
	to 12/31/10 Resi	ident # 99 had 12					
	behaviors in whi	ich staff attempted 24					
	interventions wi	th 6 of those being					
	effective, from 1	/7 to 1/31/11 Resident #					
	99 had 21 behav	riors in which staff					
	attempted 44 int	erventions with 9 being					
	1 -	2/1 to 2/15/11 Resident #					
		iors in which staff					
		erventions with 5 being					
	1 -	om 3/2 to 3/19/11					
		ad 3 behaviors in which					
		3 interventions with no					
	intervention effe						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE **LUTHERAN COMMUNITY HOME INC** SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE In an interview with the Assistant Director of Nursing, on 4/13/11 at 8:30 A.M., she indicated the care tracker system is Each resident must receive and the facility F0309 must provide the necessary care and services SS=G to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F0309 F 309It is the policy of this facility 05/10/2011 Based on interview, observation to provide the necessary care and and record review, the facility services to attain or maintain the highest practicable physical. failed to ensure a resident mental, and psychosocial experiencing pain and signs and well-being, in accordance with the symptoms of a fracture received comprehensive assessment and plan of care.I. Corrective Action prompt care to manage pain and For The Resident Affected:The receive prompt treatment for the resident identified was transferred to the hospital, treated for a right fracture, for 1 of 10 residents hip fracture, and returned to our reviewed with injury and facility where she received skilled care and therapy until April 22, complaints of pain following a fall, 2011. Upon her return, staff in the sample of 21. Resident #61. ensured that she had medication ordered for pain and this is being administered per physician Findings include: orders.II. Other Residents Having The Potential To Be Affected:All residents who are 1. Resident #61 was identified on experiencing pain from a fall have the initial tour of the locked the potential to be affected. The pain management policy was dementia unit, on 4/11/11 at 10:15 reviewed and evaluated based on A.M., by LPN #19, as having had current evidence based practice. The policy was updated. recent falls and a hip fracture. (Attachment titled Pain Resident # 61 was observed on Management).III. Systemic 4/12/11 at 9:30 A.M. in her room Changes And Steps To Ensure That The Deficient Practice Does

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TEEX11 Facility ID:

000347

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Not Recur: Mandatory education in bed. will be held with all nursing staff, nurses and certified nursing Resident # 61's clinical record was assistants, on May 4th and 5th, 2011. (Attachment titled reviewed on 4/11/11 at 10:30 A.M. Required Education for Nursing The most recent Minimum data set Staff). The physician notification policy will be reviewed in detail. assessment (MDS) dated 3/11/11, (Attachment titled Physician indicated the resident was severely Notification). It was stressed that there are times when it is cognitively impaired, required appropriate to fax the physician assistance with bed mobility, and there are times when immediate notification is required. transfers and ambulation, and was such as for complaints of pain frequently incontinent of urine. without an order for medication, Balance during transitions and an increase in pain that is not controlled, a fall, or a fracture. walking was not steady, only able Staff will also be educated to stabilize with human assistance about the plan to prevent any delay in treatment for a resident while moving from seated to with a fracture. All x-ray results standing and moving on or off the will be reviewed by a second nurse to ensure that nothing is toilet. The resident had fallen since missed. Mobilex, our x-ray the last assessment, with no provider, will notify the director of nursing of all fractures. If unable injuries. to reach the director of nursing, the administrator will be called. The care plan, dated 10/1/10, Staff members were educated about this process in their April included a problem for "Resident at staff meeting, (Attachment titled high risk for falls and pain right hip Nurses Meeting Agenda), and will be again in meetings held May and right groin pelvic area, updated 4th and 5th, 2011. Staff members 9/21/10, start date 5/15/2008, FALL will also be educated on the pain management policy of the facility. 11/16/10 at 1225 a.m." Another It will be stressed that it is not problem, dated 9/21/10, for appropriate to administer a pain medication ordered for a specific "resident with onset of acute pain in area of pain for another area. An right hip and right groin/pelvic audit tool was developed that will 000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155715	A. BUI	LDING	00	04/13/20	
		100710	B. WIN	_	PRESIDENCE CONTROL CON	04/13/20	J11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		tions included:			be used by the Director of Nursing or her designee to		
	"administer pa	in meds as ordered,"			ensure that physician notifica	ition	
	"administer pr	n (as needed) pain			is appropriate and timely for		
	meds as neede	d, ask res to rate pain			residents who have experien a fall. PRN medications will		
	scale 1 to 10,"	"monitor for			be audited to ensure that the		
	· ·	of pain meds, notify			administered timely and that		
		t controlled with			are appropriate orders in place (Attachment titled Fall Audit	ce.	
	current pain m				Tool). IV. Monitoring of		
					Corrective Action:Audit result	ts will	
	Nurses notes	datad 2/20/11 at			be reviewed by the Quality Assurance Committee month	nlv	
	· ·	dated 3/29/11 at			for six months. If the approp	· .	
	_	icated "Resident			care and documentation is		
	_	r by bed of room (not			completed 100% of the time, monthly monitoring will be		
	· ·	ruising/skin tears. No			stopped and random audits will		
	outward signs	of broken hips can			occur. A sample size of 25%	will	
	abduct and add	duct both legs			be completed monthly. If opportunities for improvemer	nt are	
	without proble	em. No pop/click			identified through the randon		
	heard when me	oving legs, stood			audits, a full audit will resume	e. If	
	with transfers	without problems			after six months of random audits, 100% compliance		
		sident complains of			continues, auditing will stop.	The	
		Hydrocodone 7.5/500			results of all audits will be		
	given at this ti	•			reviewed by the Quality Assurance Committee month	nlv.	
	~	ould like x-ray"				,.	
	Di-asked if We	outa like a-lay					
	The Deat Fell 1	Reporting Form					
		1 0					
		29/11 7:00 P.M.					
		history of falls,					
		oor in resident's room					
	(not her own),	lost					
	strength/weaki	ness, activity during					

000347

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIER		p. will	STREET A	NDDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	the incident was bedroom (not bedroom (not bedroom (not bedroom (not bedroom (not bedroom (not bedroom was weakness physician was 11:00 P.M. Scontributing to increased configuration another resident tried to transfe wheelchair to interventions needed." LPN #1, on 4/provided a fax 10:50 P.M. whon floor-sitting bruising/skin to sign of broken adduct both leproblem-No powhen moving transfers from	as -ambulating in her room), getting up hir, devices in and anti roll back at's physical status and unsteady gait, notified 3/29/11 at hummary of factors of falls: Resident has fusion, thought at's bed was hers, or self from bed by self, future redirect when 11/11 at 12:15 P.M., dated 3/29/11 at hich indicated "found g by bed. No lears. No outward hips can abduct and		TAG		ALE	DATE
	_	assist. Resident left leg pain would					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	you like x-ray Nurse notes, d A.M. "Reside assist of CNA elbow-purple l lateral forearm small purple b thigh lateral as scrapes, horize upper leg later small purple b ADON, MD n complains of p Fall follow up dated 3/30/11 injuries noted- on and near ell abrasion left u aspect near kn color .5 cm ab line, 6 cm leng not open, com complains of 1 complained pa	ated 3/30/11 3:30 nt showered with Noted right bruise, .5 cm right a proximal to elbow, ruise .5 cm right mid spect 3-4 cm 4 red bontal unopened, right al aspect above knee, ruise, day nurses, otifiedResident brain in left leg" documentation, at 5 a.m. indicated, 2 bruises on left arm brow, area of scrape pper leg, lateral lee, 1 bruise red in love knee, 3 reddish leth 1 cm width area ments: "resident leg pain at 2:55 a.m. lin being pretty bad. APAP 7.5/500 one		TAG	DEFICIENCY)		DATE

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N	MULTIPLE CO	NSTRUCTION		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155715	A. BU	ILDING	00		COMPL 04/13/2	
		1307 13	B. WI				04/13/2	011
NAME OF P	ROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STA			
LUTHER	AN COMMUNITY H	IOME INC			OUR, IN47274	, L		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION DATE
IAG				IAG	DEF	,		DATE
	·	dated 3/30/11 8:40						
		d "complaints of pain						
		emity, given prn (as						
	needed) Hydrocodone 7.5/500							
		ime. CNA (certified						
	-	ant) reported resident						
	•	in when attempted						
		ttempt care at a later						
	time"							
		documentation,						
	dated 3/30/11							
	indicated "que	estion if fracture left						
	lower leg, to re	equest order for x-ray						
	from physician	ncomments:						
	complains of l	eft groin/left hip						
	pain, screams	out with slight						
	attempt with ra	ange of motion left						
	_	ty, complains of pain						
		eft foot in toward had,						
	_	er for x-ray left lower						
	_	n doctorresident has						
	_	with no weight						
	bearing or tran	•						
	_	/30/11 1:45 P.M. new						
		left hip, femur, knee,						
	tibia, foot."	ion inp, ioniui, kiice,						
	11010, 1001.							
	Nurses notes in	ndicated: "3/30/11 at						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	TEEX1 ²	Facility 1	ID: 000347	If continuation sh	neet Pa	ge 42 of 113

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	requested an x call" "3/30/11 1:05 Droffice call may obtain x-rextremity, left tibia, footcal service) to do possible" "3/30/11 1:15 fax from 3/30/rorder received The Assistant on 4/12/11 at a fax dated 3/3	led Droffice, -ray order, to return p.mfrom ed with new order ray of lower left hip, femur, knee led (mobile x-ray x-rays as soon as p.m. received copy of 11 7:35 A.M. no new ." Director of Nursing, 11:00 A.M., provided 30/11 at 7:30 a.m.				NTE .	
	purple bruise in .5 diameter bruise in lateral aspect 3 cm by 1 cm no lateral thigh clum diameter p 2:45 a.m. gave	ght elbow .5 diameter right lateral fore arm uise, right mid thigh 8 red lines, scrape 4 o open area, right ose to knee small .4 urple bruise. Noted e shower." The ponse to the fax was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155715	A. BUII		00	04/13/2011
		1007.10	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	0
NAME OF F	PROVIDER OR SUPPLIER				ST CHURCH AVE	
LUTHER	AN COMMUNITY H	OME INC		I	DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG			+	IAG	DEFICIENCE)	DATE
	dated 3/30/11	9.33 a.III.				
	Nurses notes in	ndicated:				
	 "3/30/11 3:30	p.m. (mobile x-ray				
	l .	o x-ray left leg."				
	Í ,	o.m. (mobile x-ray				
		a-raying left leg. Res				
	l -	pain during procedure.				
		rocodone 7.5/500 mg				
	tab for pain. w					
		p.m. received results				
	of left hip, left	-				
	•	eft subcapital fracture				
		isplacementfaxed				
		filed results under				
		illed results under				
	x-ray results."					
	"3/31/11 8.30	A.M. spoke with				
		•				
	Dron phone	•				
		states he will call and				
		ents (family member)				
		ct and orthopedic				
	_	all us back awaiting				
	return call"					
	 "3/31/11 1015	a.mfrom				
		ed with new order to				
		mbulance tofor				
	Tansport via a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SU COMPLE		
ANDILAN	or correction	155715	A. BUI			04/13/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			111 WE	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		SEYMO	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
_	direct admit'						
	"3/31/11 11 A	(hospital) supervisor					
		t will need to go to					
	_	ore being admitted to					
	(hospital) per l						
	orthopedic doc	etor)"					
	•	,					
	The medicatio	n administration					
	records for Ma	arch 2011 indicated					
	an order for "H	Hydrocodone 7.5					
	mg/APAP 500	one, take one orally					
	every 4 hours	as needed for oa/right					
	hip(osteoarthri	itic) pain." The					
	Hydrocodone	was documented to					
	have been give	en 3/29/11 at 10:21					
	p.m. and on 3	/30/11 2:55 a.m.,					
	8:44 A.M., 3:4	7 P.M. and 10:55					
	P.M. No medi	cation was					
	administered of	on 3/31/11 prior to					
	transport and r	nore x-rays. The					
	controlled drug	g record indicated the					
	last dose of Hy	ydrocodone					
	administered p	orior to 3/29/11 at					
	10:30 A.M. wa	as January 12, 2011.					
	The resident al	lso had an order for					
	acetaminopher	n 325 mg for pain as					
	_	as documented to					
	have last been	administered					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3/17/11. The facility lacked evidence of having contacted the physician for pain medication ordered for the left hip pain or having administer medication to effectively control the resident's pain in the left hip from the displaced fracture. 3.1-37(a)F0314 Based on the comprehensive assessment of SS=G a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. F314 Tx/Services To F0314 05/10/2011 Based on observation, interview, Prevent/Heal Pressure SoresIt is and record review, the facility the policy of this facility to ensure failed to ensure physician's orders that a resident who enters this facility without pressure sores were followed for treatment of heel does not develop pressure sores pressure ulcers for Resident #70 unless the individual's clinical condition demonstrates that they and failed to implement adequate were unavoidable; and a resident interventions to promote healing of having pressure sores receives necessary treatment and services a heel pressure area for Resident to promote healing, prevent #34 resulting in Resident #34's heel infection and prevent new sores from developing.I. Corrective pressure area progressing from a Action For Residents Affected:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TEEX11

Facility ID:

000347

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155715	B. WIN	NG		04/13/2	011
NAME OF	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
THINE OF	I KO VIDEK OK SOI I EIEI			1	ST CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME INC		SEYMO	DUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	fluid filled bli	ster to an unstageable			Resident # 34 - The resident		
	area. This aff	ected 2 of 4 residents,			noncompliant in keeping her elevated when sitting in a ch		
		oressure ulcers, in a			her wheelchair. A pressure	all Oi	
	_	ressure dicers, in a			relieving boot was applied to	the	
	sample of 21.				resident that should be in pla		
					when she is out of bed. This	3	
	Findings Inclu	ıde:			intervention was added to the		
					care plan and communicated		
					staff through Caretracker, ou electronic documentation	ır	
	I. During init	ial observation tour			system. The resident was		
	on 04/11/11 at	t 10:15 a.m. with Unit			educated on this new		
	Manager (UM	D #13 present			intervention. Resident # 70	-	
	_ ,	was identified as			Staff members were educate		
					that the only time this reside	nt	
	being reliable	for interview, as			should be without her waffle	tina	
	requiring assis	stance of two staff for			boots is when she is ambula or participating in therapy. H	•	
	transfers, and	as having an			care plan was reviewed and	101	
	1	lcer (According to			updated.II. Other Residents		
	_	· · · · · · · · · · · · · · · · · · ·			Having The Potential To Be		
	Pressure Ulc	ers in the Long-Term			Affected: All residents havin	g	
	Care Setting C	Clinical Practice			pressure sores or at risk of	0.40	
	Guideline date	ed 2008, unstageable			developing pressure sores h the potential to be affected.		
		Full thickness tissue			pressure risk assessment so		
					was reviewed for all resident		
		the base of the ulcer			the facility. The care of all		
	is covered by	slough [yellow, tan,			residents at risk of developin	•	
	gray, green or	brown] and/or eschar			pressure sore and those with pressure sores was reviewed		
		black] in the ulcer			ensure that the appropriate	u lO	
	-	older in the theor			interventions were in place a	ınd	
	bed).				the care plan was accurate.		
					the attached audit tool.		
	On 04/12/11 a	t 10:30 a.m. Resident			(Attachment titled Pressure I	Jicer	
	#34 was obser	eved resting in bed			Prevention Audit Tool).III.	s To	
		•			Systemic Changes And Step Ensure That The Deficient	10	
	_	heel on a float. The			Practice Does Not Recur:		
	area was obse	rved to be black in the			Mandatory Education will be	held	

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155715	B. WIN			04/13/2011
			P		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				ST CHURCH AVE	
LUTHER	AN COMMUNITY H	IOME INC			OUR, IN47274	
						(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	(X5) COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
1110		·	+	1110	with all of the facility nurses	
		in pulled away from			certified nursing assistants o	
	the eschar (bla	ck/necrotic tissue)			May 4th and 5th, 2011.	
	around the bot	tom with reddened			(Attachment titled Required	
	edges				Education for Nursing Staff).	The
	04500				pressure ulcer prevention	d the
					program will be reviewed and importance of the proper and	• • • • • • • • • • • • • • • • • • •
		t 12:00 p.m., 12:40			timely implementation of pre-	
	p.m., 1:00 p.m	ı., 1:40 p.m., 4:00			relieving devices will be stres	
	p.m., and 5:00	p.m., Resident #34			The wound care nurse or	
	_	in her room, seated in			designee will audit all new	. that
		*			admissions weekly to ensure the assessments are comple	
		r. The resident was			and the appropriate interven	
	observed to be	wearing fuzzy socks			are in place and implemente	• • • • • • • • • • • • • • • • • • •
	and to have he	r feet positioned with			The wound care nurse or	
	the heels of he	er feet flat on the foot			designee will also assess the	
	pedals of the v	wheelchair			care plan of any resident with pressure ulcer to ensure that	I
	pedais of the v	viiceichair.			appropriate treatment and	
					interventions are in place.	
	Interview of R	esident #34 on			(Attachment titled Pressure l	Jicer
	04/12/11 at 12	:40 p.m. indicated			Prevention Audit Tool).IV. Monitoring of Corrective	
	she had a "plac	ce" on her right heel.			Action:Audit results will be	
	_	ndicated she was not			reviewed by the Quality	
					Assurance Committee month	nly
		or when the area			for six months. If the approp	riate
	started.				care and documentation is	
					completed 100% of the time, monthly monitoring will be	
	Interview of R	esident #34 on			stopped and random audits v	will
	04/12/11 at 4·0	00 p.m. indicated no			occur. A sample size of 25%	• • • • • • • • • • • • • • • • • • •
		•			be completed monthly. If	.
	one had ever said anything to her about keeping her heels elevated while she was in her wheelchair. The resident indicated she had been				opportunities for improvement identified through the randon	
					audits, a full audit will resum	
					after six months of random	
					audits, 100% compliance	
	in her wheelch	nair since the			continues, auditing will stop. results of all audits will be	The
					results of all addits will be	

000347

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00		3) DATE SURVEY COMPLETED 04/13/2011	
	PROVIDER OR SUPPLIER		P. WIIV	STREET A	DDRESS, CITY, STATE, ZIP COD ST CHURCH AVE JUR, IN47274	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE	(X5) COMPLETION DATE
TAG	interview on 0 except to get us bathroom. Interview of L at 1:00 p.m. in was admitted to blister on her reblister had populated at 1:00 p.m. in was admitted to blister had populated for the hall Resided 04/12/11 at 5:0 was not aware heels had been wheelchair per After the interdirectly to the after several at position the resoft the foot ped Interview of C hall Resident # 04/12/11 at 5:3 Resident #34 se	4/12/11 at 12:40 p.m. up once to go to the PN #10 on 04/12/11 dicated Resident #34 to the facility with a right heel and the oped and left a "sore." N #11 (working on ent #34 resided on) on 05 p.m. indicated she that Resident #34's a flat on the dals for 5 hours. view, RN #11 went resident's room and extempts, was able to sident's right heel off all with a pillow. NA #12 (working the #34 resided on) on 80 p.m. indicated		TAG	reviewed by the Quality Assurance Committee	/	
	evening shift.	CNA #12 indicated the resident about					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	' '	ght heel elevated, but dn't like to lay down.					
	at 9:45 a.m. in worked PRN (floor Resident she was aware supposed to ha when in bed, b told the reside	dicated the CNA as needed) on the #34 resided on, and the resident was ave her legs elevated but had never been int was to have her when up in her					
	record on 04/1 indicated the f	_					
	included, but whigh blood pre	nad diagnoses which were not limited to, essure, diabetes, and osteoarthritis.					
	dated 12/29/10	ransfer Report" sheet,), indicated Resident re "boggy-red."					
	 	, dated 12/31/10 at cated, "Large closed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLI		
		155715	A. BUI B. WIN	LDING IG		04/13/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE	I	
LUTHER	AN COMMUNITY H	OME INC		SEYMC	DUR, IN47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	blister was not	ed to (right) heel at					
	(2:00 a.m.) th	is (night). Heel					
	elevated off be	ed. (Approximate)					
	measures 6.2 (by) 5 cmWound					
	Care Nurse no	tified. (Medical					
	Doctor) notifie	edBlister is raised.					
	No discoloration	on around blister. No					
	bruising noted	. Area pink."					
	_	ated 12/31/10 with					
	1 *	14/11, 01/28/11, and					
		ated Resident #34					
	^	area on her right					
		al" of the care plan					
		a will show increased					
	1 *	and a decrease in size					
		s." Hand written					
		l section was, "Blister					
	1 11	(treatment) as					
	`	te). Area continues					
		(Wound Nurse)					
	. ` ′	sit (every) 2 weeks.					
		7/11. Care plan					
		- (Antibiotic) per MD					
	order, Treatme	· · · · · · · · · · · · · · · · · · ·					
	· ·	igns/symptoms) of					
		as increased redness,					
		ninage & report to					
	MD as needed	, Monitor for lack of					

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155715	B. WIN	G		04/13/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
LLITHED	AN COMMUNITY H	IOME INC		1	ST CHURCH AVE DUR, IN47274	
					JUR, 1N47274	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	improvement or need to change					
	(treatment).	C				
	The care plan	lacked				
	documentation					
		the resident's right				
		in wheelchair and				
	_	entation supporting				
		the resident's right				
	heel when she					
	lieer when she	is iii ocu.				
	A nurgala nota	dated 12/20/10 at				
	· · · · · · · · · · · · · · · · · · ·	, dated 12/30/10 at				
	•	icated Resident #34				
	_	ve and pleasant and				
	_	n being turned and				
	repositioned.					
	· · · · · · · · · · · · · · · · · · ·	, dated 01/19/11 at				
	1:30 p.m., indi	icated, "Right heel				
	has (changed)	over the week; skin				
	under popped	blister has turned				
	yellow and me	easures 4 cm (by) 4				
	cm (with) blac	k bruise measuring				
	2.5 cm (by) 1.5 cm; (physician)					
	, .	ange) & asked if OK				
	,	und specialist); OK				
	,	teral) heels elevated				
	off bed; in cha	*				
	· ·	na to (right lower				
	extremity)"	10 (115111 10WCI				
	CAUCHILLY J					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION		(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUIL	DING	00		COMPL 04/13/2		
		1007 10	B. WIN				04/13/2	011
NAME OF F	PROVIDER OR SUPPLIER			l	DDRESS, CITY, STATEST CHURCH AV	*		
LUTHER	AN COMMUNITY H	OME INC		l	UR, IN47274	L		
(X4) ID		TATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		CIENCY)	_	DATE
	A nurse's note,	, dated 02/03/11 at						
	12:00 p.m. ind	icated, "Updated						
	(Medical Doct	or) (with) wound						
	nurse recomm	endations and orders						
	received. (1) c	leanse wound (right)						
	heel (with) sal	ine (with) each						
	` ′	nge, apply skin prep.						
	`	periwound. Apply						
	Allevyn thin. Seal edges with skin							
	*	(every) 3 days. Next						
	1 1	sit 02/17/11 at 2:00						
	p.m."	51t 02/1//11 at 2.00						
	μ.III.							
	 An "MD Progi	ress Note," dated						
	_	cated, "Wound Care						
	·	eable pressure ulcer						
	_	Covered 100% black						
	` • ′	r beginning to pull						
		ges. Dimensions 3.8						
	, ,	Periwound intact.						
	` • ′	palpation. Small						
		* *						
	· ·	us drainage present						
	on removed dr	•						
		Allevyn thin to assist						
	· · · · · ·	c debridement of						
		w orders. Next						
	(appointment)	3/3/11." This entry						
	was signed by	the wound nurse.						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	TEEX11	Facility I	D: 000347	If continuation sh	neet Pa	 ge 53 of 113

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPLI	
	or container	155715	A. BUI B. WIN			04/13/20	
NAME OF E	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
					ST CHURCH AVE		
	AN COMMUNITY H			l	DUR, IN47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
IAU	A nurse's note, 7:35 a.m., indi #34) pleasant a (Alert & orien needs known knownEdem lower extremit A nurse's note, 2:30 p.m., indi wound assesse Area measure (width). Depti determine. Ar to the wound b (with) black estissue). (Conti (treatment) of (Normal Saline eschar, apply of dressing) & codressing. Will	dated 03/05/11 at cated, "(Resident and cooperative. ted (times) 3. Makes .Makes needs a continues to right cies" dated 03/10/11 at deated,"(Right) heel ed & measured today. 4.0 cm x (by) 4.7 cm h is unable to rea is unstageable due bed being covered schar (necrotic finue) current		IAU			DATE
	Healing Recor	ily Wound/Skin ds" were provided by 4/12/11 at 11:00 a.m.					

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		ì	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIED		р. w.п.	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE			(X5) COMPLETION DATE
	The records in following:	ndicated the					
	stage 2 "close on Resident # According to the Long-Terr 2008 - a stage defined as, "P of dermis presopen ulcer with bed, without spresent as an important open/ruptured On 01/03/11 If "intact fluid fir right heel. On 01/06/11 and measured 4 cm. The resistin was peeled On 01/09/11 remained on If the content of the conten	Resident #34 had an lled blister" on her the blister was open 3 cm (centimeters) by cord indicated the "top ed off."					

NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC INC. I	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715				LDING	ONSTRUCTION 00	(X3) DATE COMP 04/13/	LETED
LUTHERAN COMMUNITY HOME INC (X9.10) SUMMARY STATEMENT OF DEPICENCIES (ACH) DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 01/14/11 a stage 2 area remained on Resident #34's right heel. The record indicated the wound bed was a "black/purple bruise." On 01/16/11 a stage 2 area remained on Resident #34's right heel and the wound bed was "brown and healing." On 02/21/11 the area on Resident #34's right heel was unstageable and had Alleyn (sic) (wound dressing) "thin in place." On 02/25/11 area on Resident #34's right heel was unstageable, and had serosanguinous drainage. (This entry was the first to indicate drainage from the wound). Wound healing records, dated 02/26/11 through 03/18/11 indicated there was no change in the wound.	NAME OF I	PROVIDER OR SUPPLIE	R	-				
PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) On 01/14/11 a stage 2 area remained on Resident #34's right heel. The record indicated the wound bed was a "black/purple bruise." On 01/16/11 a stage 2 area remained on Resident #34's right heel and the wound bed was "brown and healing." On 02/21/11 the area on Resident #34's right heel was unstageable and had Alleyn (sic) (wound dressing) "thin in place." On 02/25/11 area on Resident #34's right heel was unstageable, brown and had serosanguinous drainage. (This entry was the first to indicate drainage from the wound). Wound healing records, dated 02/26/11 through 03/18/11 indicated there was no change in the wound.	LUTHER	AN COMMUNITY I	HOME INC					
remained on Resident #34's right heel. The record indicated the wound bed was a "black/purple bruise." On 01/16/11 a stage 2 area remained on Resident #34's right heel and the wound bed was "brown and healing." On 02/21/11 the area on Resident #34's right heel was unstageable and had Alleyn (sic) (wound dressing) "thin in place." On 02/25/11 area on Resident #34's right heel was unstageable, brown and had serosanguinous drainage. (This entry was the first to indicate drainage from the wound). Wound healing records, dated 02/26/11 through 03/18/11 indicated there was no change in the wound.	PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
on set 21, 11 the anomponent men		remained on I heel. The rec wound bed was bruise." On 01/16/11 a remained on I heel and the v "brown and he on 1 heel and the v "brown and he on 02/21/11 #34's right heand had Alley dressing) "this on 02/25/11 a right heel was and had seros (This entry was drainage from Wound healing 02/26/11 throwindicated ther the wound.	Resident #34's right ord indicated the as a "black/purple a stage 2 area Resident #34's right wound bed was ealing." the area on Resident el was unstageable en (sic) (wound in in place." area on Resident #34's sunstageable, brown anguinous drainage. as the first to indicate in the wound). ag records, dated ugh 03/18/11 e was no change in					

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPI	
		155715	A. BUI B. WIN	LDING IG		04/13/2	2011
NAME OF I	PROVIDER OR SUPPLIER		P. WII	_	ADDRESS, CITY, STATE, ZIP CODE	1	
	AN COMMUNITY F			<u> </u>	DUR, IN47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	on Resident #3	34's right foot had					
	purulent drain	age, a "moderate"					
	odor, an "escl	nar" (black) wound					
	bed and edema	atous surrounding					
	tissue.						
	Wound healing	g records, dated					
	03/23/11, 03/2	4/11, and 03/26/11					
	indicated no c	hange in the wound					
	area.						
	Wound healing	g records, dated					
	04/09/11, 04/1	0/11, and 04/11/11					
	indicated the o	only change in the					
	wound was the	e odor had decreased					
	to a "slight" o	dor.					
	A MDS (minii	num data set)					
	assessment, da	ated 01/11/11,					
	indicated Resi	dent #34 was alert					
	and oriented a	nd understood what					
	others said to	her and was					
	understood by	others. The					
	assessment ind	dicated the resident					
	had impaired i	range of motion with					
	her lower extr	emities, required					
	extensive assis	stance of staff for					
	transfers and h	nad (1) stage 2					
	pressure ulcer						
	l						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715				LDING	ONSTRUCTION 00	(X3) DATE COMPI 04/13/2	ETED
NAME OF I	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE	•	
LUTHER	AN COMMUNITY I	HOME INC			OUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	A physician's March 2011 in orders: An order, date "elevate bilate remedy three An order, date "Cleanse ulce apply Santyl ethick and securchange daily." An order, date	re-write order for included the following and 01/03/11, indicated, apply skin times a day." ed 01/03/11, indicated, in on (right) heel, are on (right) heel, are with Allevyn in with cover roll are with cover roll are with cover roll are with cover roll.		IAU	DETELENCT)		DATE
	heel (with) (n Santyl (wound only, cover (v secure (with) daily.' A Therapy no service date of the resident's to, "Discharge	eanse ulcer on (right) ormal saline), apply d treatment) to eschar with) Allevyn thick & cover roll - (change) te with a start of f 12/31/10 indicated discharge plans were e home and with caregiver."					

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	COMPI	
1111212111	or conditions	155715		LDING		04/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER						
LUTHER	AN COMMUNITY H	IOME INC		SEYMO	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		s clinical record		IAG	- 15 Y		DAIL
		entation supporting					
		peing non-compliant					
	with positioning	ng and lacked					
	documentation	n on resident being					
	educated on in	nportance of keeping					
	heel elevated v	while up in					
	wheelchair.						
	Interview of th	ne DON on 04/14/11					
	at 10:15 a.m.,	indicated bed					
	pillows would	n't work for keeping					
	the resident's l	neel elevated off of					
	the wheelchain	pedals due to sliding					
	off. The DON	I indicated she would					
	talk to Therapy	y about getting					
	something to u	ise on the wheelchair					
	pedals so the r	esident's heel would					
	be elevated of	f of pedals when she					
	was up in her	wheelchair.					
	The facility fa	iled to provide					
	documentation	n supporting CNAs					
	and nursing sta	aff were educated on					
	interventions t	o keep Resident					
	#34's heel elev	vated while she was					
	sitting up in he	er wheelchair.					
	2. On the init	ial tour, on 4/11/11 at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OI CORRECTION	155715		LDING	00	04/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		SEYMO	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
		PN # 19 indicated					
	Resident # 70 had dementia and a						
	pressure sore on her left heel which						
	•	n the facility. LPN					
	•	Resident # 70 utilized					
		nd a heel elevator.					
	On 4/11/11 at	4:40 P.M., Resident #					
		ed to be sitting in a					
		the dining room.					
		was observed to have					
		on the left foot.					
	a warre						
	On 4/12/11 at	8:15 A.M., Resident					
		rved to be sitting in a					
		the dining room.					
		was observed in an					
		ent # 70 had bilateral					
	socks and shoe						
	On 4/12/11 at	9:10 A.M., LPN # 21					
	was observed						
		esident # 70's left					
	_	to the left heel was					
		over the entire heel.					
		ared as a loose hard					
		overing half the area					
		_					
	_	of the area was dark					
	red/purple in c	0101.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00	(X3) DATE COMP 04/13/2	LETED
NAME OF	PROVIDER OR SUPPLIE	R	 1	DDRESS, CITY, STATE, ZIP CODE	•	
LUTHER	RAN COMMUNITY H	HOME INC	1	ST CHURCH AVE OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
TAG	On 4/12/11 at # 70 was observed to he and shoes on. The clinical reformation of the c	9:20 A.M., Resident erved to be sitting in a the therapy desident # 70 was ave bilateral socks ecord for Resident # yed on 4/11/11 at 1:00 ord indicated Resident moses that included imited to dementia ations and confusion. Inimum data set] ated 2/16/11, ident # 70 had inition, and required stance of two with and transfers. The dicated Resident # 70 re areas. dated 11/26/09, oblem of "Potential down R/T [related to]	TAG	DEFICIENCY)		DATE

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155715	- 1	LDING		04/13/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			111 WE	ST CHURCH AVE	
LUTHER	AN COMMUNITY H	OME INC		SEYMO	DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
	with turning a	nd repositioning Q				
	_	nd PRN [as needed]				
	and Keep heel					
	1	1				
	A Care plan, d	ated 3/1/11, indicated				
	a problem of "	Pressure area L [left]				
	heel." The inte	erventions were "1.				
	ATB [antibioti	c] per MD order. 2.				
	TX [treatment	as ordered. 3.				
	Monitor for s/s	s [signs and				
		infection such as				
	-	ess, warmth, or				
	drainage and r	eport to MD as				
	needed. 4. Mo	nitor for lack of				
	improvement of	or need to change TX.				
	_	or in bed. 6. Waffle				
	boots BLE [bi]	lateral lower				
	extremities]. 7	. No shoes."				
	_					
	A Wound Care	Evaluation, dated				
	3/3/11, indicat	ed 'Pressure-				
	Stage II 6.0 x 8	8.0 x 0.2Wound				
	bed: pink with	partial skin flap in				
	placePt [pati	ent] has developed a				
	pressure area t	o heel that began as a				
	large blister. H	las now ruptured				
	leaving open v	vound with partial				
	skin flap in pla	ace requiring				
	treatment "					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPL 04/13/20	ETED
	PROVIDER OR SUPPLIER		•	111 WES	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	indicated "Do Xerofoam and to L heel. App and dry thorous sock and waffl shift indef [indicated had a decline is staying in bed The Director of the recliner was	der, dated 3/31/11, C [discontinue] foam drg [dressing] ly skin prep to L heel ghly before putting le boot on q [every] definitely]. " w with the Director of ssistant Director of 12/11 at 8:30 A.M., Resident # 70 had in condition and was or the recliner more. If Nursing indicated as the issue causing Resident # 70's heel.					
F0323 SS=G	environment remain hazards as is possible receives adequated devices to prevent Based on interview observation, the Resident #99 receinterventions to presulting in a fraction.	nsure that the resident ins as free of accident sible; and each resident expervision and assistance accidents. ew, record review and facility failed to ensure eived supervision and prevent recurrent falls eture, failed to ensure supervised so she did	F0.	323	F 323 Free Of Accident HazardsIt is the policy of this facility to ensure that the resi environment remains as free accident hazards as is possil and each resident receives adequate supervision and assistance devices to preven	dent of ble;	05/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE **LUTHERAN COMMUNITY HOME INC** SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE accidents.I. Corrective Action For not attempt to transfer herself without Residents Affected: Resident # 61 assistance and did not wander into others' - The fall risk assessment of the rooms looking for her bed, resulting in a resident was reviewed. The care hip fracture, failed to ensure Resident #98 plan was reviewed and the appropriate interventions are in was supervised in order to prevent falls place including alarms to alert the while attempting to transfer himself staff to her attempts to transfer and/or go to the bathroom, and to prevent alone. The resident received Resident #97 from attempting to help therapy to increase her strength Resident #98 and turn off alarms, for 3 of and activity tolerance, and also to educate staff on safe transfers. 10 residents reviewed for falls in the Staff education was completed on sample of 21. her care.Resident # 98 - The fall risk assessment of the resident Findings include: was reviewed. The care plan was reviewed and updated. The resident's spouse attempts to 1. On the initial tour, on 4/11/11 at 10:15 assist the resident without the A.M., LPN # 19 indicated Resident # 99 knowledge of the staff. A wireless had dementia, and has had several falls sensor is now being used that the spouse cannot disconnect. The and a recent fracture. Resident # 99 alarm sounds at the nurses utilized a wanderguard, chair alarm and station not in the resident's room bed alarms. so staff can respond immediately to the spouse's attempts to help her husband. The time of the The clinical record for Resident # 99 was resident's diuretic has been reviewed on 4/11/11 at 11:45 A.M. The changed and he is being toileted record indicated Resident # 99 had every hour after 3 PM. Staff diagnoses that included but were not education was completed on his care.Resident # 99 - The fall risk limited to dementia and anxiety. The assessment of the resident was MDS [minimum data set] assessment, reviewed. The care plan was dated 1/20/11, indicated Resident # 99 reviewed and the appropriate had impaired cognition, and had no interventions are in place including alarms to alert the staff behaviors. Resident # 99 required limited to her attempts to transfer and assistance of one with bed mobility. ambulate without supervision. transfers and ambulation. Resident # 99 She is being evaluated for the had 1 fall with no injury and 2 or more benefit of initiating therapy services. An individualized falls with injury since the previous

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155715	B. WING			04/13/2	011
		l .	B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ST CHURCH AVE		
LUTHERAN COMMUNITY HOME INC				1	DUR, IN47274		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	assessment dated	· · · · · · · · · · · · · · · · · · ·	1		behavior care plan has been		
	assessment dated	1 10/20/10.			implemented for this residen		
	A 1 1 . 4 .	110/14/10 : 1:1 -			Staff education was complete	ed on	
	1 -	ed 10/14/10, indicated a			her care.II. Other Residents		
	1 ^	ident at risk of falling d/t			Having The Potential To Be		
	1 * *	nit to facility and hx			Affected:All residents who ar		
	1	dering. Dx [diagnosis] of			high fall risk have the potenti be affected. The falls policy		
	dementia." The i	nterventions were "1.			procedure was reviewed and		
	Call light within	reach with frequent			evaluated based on current		
	reminders on ho	w to use. 2. Side rails to			evidence based practice.		
	assist with transf	fers and bed mobility. 3.			(Attachment titled Fall		
	1	iness and unsteady gait.			Management). The falls poli	су	
	1	blood pressure] for			and procedure includes		
	· -	tension. 5. Res [resident]			assessment, planning, intervention, and evaluation	to	
					complete the nursing proces		
		endently. 6. Ensure res			The Post Fall Reporting Forn		
	wearing proper f	coot wear."			used after the fall and guides		
					investigation of the fall, prom		
	The fall risk asse	essment, dated 10/14/10,			physician and family notificat		
	indicated a score	e of 6. In an interview			and also interventions to pre		
	with the Director	r of Nursing, on 4/12/11			another fall. (Attachments til Post Fall Reporting Form, Fa		
	at 10:00 A.M., sl	he indicated a score of 10			Review Note, and 48-72 Hou		
	1	ted high risk for falls.			Review). An evaluation tool		
		8 1 1 1 11			used 48-72 hours after the fa		
	The Nurses Note	es, dated 10/28/10 at 2:50			ensure that interventions are		
		'Res [resident] found on			implemented, are appropriat	•	
	1				and are effective. Staff educ		
	_	oom getting ready to			was completed with the nurs staff regarding the important		
	1 ^	tripped on robe. Found			supervision for residents at h		
		nds on floor. In this			fall risk. The importance of h	•	
	1 -	hold of Activity's office.			rounding was stressed.III.	_	
	No c/o [complaints of] pain. No injury				Systemic Changes And Step	s To	
	notedrobe to b	e hemmed."			Ensure That The Deficient		
					Practice Does Not Recur:Mandatory education	vazill	
	The 10/14/10 fal	ll care plan was updated			be held with all nurses and	VVIII	
		nclude the intervention of			certified nursing assistants o	n l	
		ength of clothing (not too			May 4th and 5th, 2011.		
	Linsuic proper i	engin or croming (not too					

000347

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE **LUTHERAN COMMUNITY HOME INC** SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (Attachment titled Required long)." Education for Nursing Staff). Included in the staff education is The Nurses Notes, dated 10/30/10 7:00 a review of the fall management P.M., indicated "This nurse observed res policy, how to do a thorough fall assessment, a review of the sitting upright on shower room forms to complete that prompts floor...Observed 3 cm x [by] 0.2 cm skin the proper investigation of the fall tear to chin...(3) steri strips applied small and the proper notification of the amt blood present. Res stated I was physician and family. It will putting plates in the cabinet. Intervention: be stressed that the investigation must include critical thinking that 15 min checks by staff. Clothing was of asks questions to get to the root proper length along with proper footwear cause of the fall. All interventions worn..." should address the root cause. Staff members will be educated to look at intrinsic, extrinsic, and The 10/14/10 fall care plan was updated systemic causes. After the on 10/30/10 to include the intervention of education, new fall risk "Begin 15 min checks." assessments will be completed on every resident. An audit tool was developed to be used by the The Nurses Notes, dated 11/1/10 at 9:10 Director of Nursing or her A.M., indicated "Met with direct care staff designee to evaluate and monitor to review interventions put in place with staff's adherence to the policy fall of 10-28-10, interventions being and to ensure that the proper care of the resident occurs. Items utilized and effective." included in this audit are the date and time of the fall, the date and The Nurses Notes, dated 11/1/10 at 9:20 time of physician notification, the A.M., indicated "Met with direct care staff type and appropriateness of the notification, and the use of pain to review fall of 10-3-10 (sic), current medications to treat any injury. intervention of 15 min checks in place, (Attachment Fall Audit Tool).IV. care planned and on alert sheet." Monitoring of Corrective Action: Audit results will be reviewed by the Quality The Nurses Notes, dated 11/7/10 at 2:00 Assurance Committee monthly A.M., indicated "Res found on floor in for six months. If the appropriate room (number). Res lying on R [right] care and documentation is side, back facing door to bedroom. Res completed 100% of the time, monthly monitoring will be with no clothes on and lying near urine.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155715	B. WING			- 04/13/2011	
NAME OF I	DOLUBER OF GURRI IER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				111 WE	ST CHURCH AVE		
	AN COMMUNITY H		_		DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG			+	IAG	stopped and random audits v	will	DATE
		slept on needed to be			occur. A sample size of 25%		
	1 **	to] being dirty and			be completed monthly. If		
		nent completedGripper			opportunities for improvemen		
		ime. Res does have			identified through the randon audits, a full audit will resum		
	~	yorn at this time. 5 cm x			after six months of random	C. II	
		depth) purple goose egg			audits, 100% compliance		
		Bed pushed up against			continues, auditing will stop.	The	
		or mat laid to side of bed			results of all audits will be		
		oor. Call light placed to			reviewed by the Quality Assurance Committee month	nlv.	
		ould reach. Reminded			7.000.0.100	,.	
	resident that if needing help press call						
	light"						
	 The 10/14/10 fall	l care plan was updated					
		lude the intervention of					
	"Toilet at 1:00 A						
	101101 at 1.00 71	.171.					
	The fall risk asse	essment, dated 11/15/10,					
		of 6. The assessment					
	indicated Resider	nt # 99 had no falls in the					
	last 3 months.						
	The Post Fall Re	porting Form, dated					
	l .	M., indicated "Date of					
	fall: 2/11/11. Tim	-					
	P.MObserved of						
	(unwitnessed)A						
	hallwayRes worrying self- cleaning,						
	restless going in/out of other resident						
	rooms hitting staff tonight. Given PRN [as						
	needed] Ativan (antianxiety						
	I - '	sed on your evaluation,					
		e care plan interventions					
		re fall from occurring?					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/13/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	 	P. ,,		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	AN COMMUNITY H			1	ST CHURCH AVE PUR, IN47274		
(X4) ID				ID			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I E	DATE
	Social Service n behavior"	otified about recent					
	P.M., indicated 'balance. I didn't bruising/bleedin another resident' Personal glasses Denies hitting he head down softly side, facing towardlese to fish tank (name). (Daught	es, dated 2/11/11 at 10:30 'Res stated I lost my hit my head. No g/skin tears notedHad s glasses at her side. and shoes on/worn. eadRes stated I laid y. Lying down on L [left] ards double doors, head kCalled daughter ter name) stated she was too. It's not medication					
	The fall risk assessment, dated 2/11/11, indicated a score of 12.						
	P.M., indicated 'to review fall of	es, dated 2/14/11 at 12:50 'Met with direct care staff 2-11-11, current herapy referral in place 1."					
		Il care plan was updated clude the intervention of Il."					
	[Assistant Direc 4/12/11 at 10:00	tiew with the ADoN tor of Nursing], on A.M., she provided the completed on 2/26/11 as					

l II		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
155715		B. WING 04/13/2011				011	
			_		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER				111 WE	ST CHURCH AVE		
LUTHERAN COMMUNITY HOME INC				1	OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP			
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	the intervention f	for the fall on 2/11/11.					
	2/15/11 at 8:10 A fall: 2/15/11. Tim trying to pick up lost balanceRes stool could be we res closely due to therapy to evaluate therapy"	porting Form, dated A.M., indicated "Date of the of fall 8:10 A.MRes napkin off of floor and is has been having loose eak from thisMonitor of acute illness loose stool atteres for need for					
	A.M., indicated 'to review effective with fall of 2-11-	s, dated 2/17/11 at 10:00 'Met with direct care staff veness of intervention -11. Intervention of delayed due to acute					
	A.M., indicated 'to review fall of monitoring res m	es, dated 2/17/11 at 10:35 'Met with direct care staff 2-15-11 intervention of hore closely D/T [due to] ng utilized care planned t."					
	2/19/11 at 5:30 P fall: 2/19/11. Tim P.MObserved of (unwitnessed)F hand bleeding sk flu, unsteady gain	on the floor R [right] posterior top of in tearweakness from					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
TANDILIAN	or conduction	155715	A. BUII			04/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		SEYMC	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
1.10		prevent a future fall from					5.112
	1 *	e clip alarm when in					
	chair. 2. Monitor	closely"					
		l care plan was updated					
		lude the intervention of					
	"Apply clip alarr	n. ··					
	The fall risk asse	ssment, dated 2/19/11,					
	indicated a score						
		l care plan was updated					
		lude the intervention of					
	"Chair pad senso	r."					
	The Nurses Note	s, dated 2/21/11 at 2:30					
		Met with direct care staff					
	· ·	veness of interventions					
	implemented wit	h fall of 2-15-11,					
		nonitoring closely D/T					
	acute illness effe	ctive."					
	The Nurses Note	s, dated 2/21/11 at 5:00					
		Met with direct care staff					
	to review fall of						
		hair pad sensor in place					
	care planned and						
		l care plan was updated					
		lude the intervention of					
	"Bed alarm."						
	The Nurses Note	s, dated 2/22/11 at 4:00					
		Res very weak from					

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Event ID: **TEEX11** Facility ID:

000347

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR COMPLETI			
AND PLAN	OF CORRECTION	155715	A. BUII		00	04/13/201 ²		
		1007 10	B. WIN		A DDDEGG CITY GTATE ZID CODE	04/10/201	'	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE			
LUTHERAN COMMUNITY HOME INC				1	OUR, IN47274			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE C	OMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		l. Appetite poor. Bed						
		es bed due to weakness						
	and res does not	always ask for assist."						
	The Post Fall Reg	porting Form, dated						
		.M., indicated "Date of						
	fall: 2/27/11. Tim	ne of fall: 8:15						
	P.MObserved of	on the floor						
	(unwitnessed)S	Stood up while in w/c lost						
	balance and fell t	to floorL elbow						
	abrasion no open	area to elbow no						
	treatment request	ted from MDnoticed						
	wire unclipped fi	rom box so alarm did not						
	soundRes sittin	ig in w/c at (hall name)						
	med cart. This nu	irse also at med cart. I						
	turned away fron	n res for 5 seconds heard						
	thump turned bac	ck around and res on L						
	_	air alarm wire leading to						
		ed so chair alarm didn't						
		and ensure chair pad						
		plugged into clip alarm						
	box"	1 66 1						
		l care plan was updated						
		lude the intervention of						
		sure chair pad sensor						
	wires are plugged	d into clip alarm box at						
	all times."							
	The fall risk asse	essment, dated 2/27/11,						
	indicated a score							
	The Post Fall Re	porting Form, dated						
		.M., indicated "Date of						
	5, 11, 11 at 1.10 1	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/13/2011	
NAME OF L	DDOMBED OD CLIDDI IEI)	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIEI				ST CHURCH AVE	
LUTHER	RAN COMMUNITY F	HOME INC		SEYMO	DUR, IN47274	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG	ŧ	Time of fall: 4:10		TAG	Dia leii.ke 1	DATE
	P.Mlost balan					
		PT [physical therapy]				
	_	visitor who left around				
	_	our evaluation, what are				
	1 ^ -	in interventions to prevent				
	a future fall fron	n occurring? walk 2 x				
	[times] a shift to	increase strength monitor				
	BP [blood press	ure] for 1 week"				
		ll care plan was updated				
		clude the intervention of				
	"Walk 2 x [times	s] a shift."				
	The fall rick acce	essment, dated 3/11/11,				
	indicated a score					
	maleated a score	01 10.				
	The Nurses Note	es, dated 3/19/11 at 5:30				
		"Res found on floor,				
	sitting in front o	f recliner in lounge area.				
	Said I was going	g to peec/o [complaint				
	of] L [left] wrist	pain, no visible redness				
	1 3	an move all extremities.				
		es slid out of rec [recliner]				
	1	lanket while attempting				
	1	st was down) Res made				
	no sounds while	*				
	recently had acu	whispering voice. Has				
	1	infectionAdded clip				
	~	sensor as interventions.				
		for protection next to				
		to use small blankets				
	that are light in					
	1	··· - U -··				I

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
and Plan of Correction IDENTIFICATION NUMBER: 155715			A. BUI	LDING	00	04/13/2011
		1557 15	B. WIN			04/13/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE	
LUTHER	AN COMMUNITY H	OME INC		1	DUR, IN47274	
			_,		0013, 1147274	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
0	regozin our ou		+	0		5.112
ı	The 10/14/10 fall	l care plan was updated				
		lude the intervention of				
	"Clip alarm."	rude the intervention of				
	Clip alailli.					
	The 10/14/10 follows:	l care plan was updated				
		lude the intervention of				
		lanket in w/c or recliner."				
	OSC SITIATI TAP UI	minted in w/c of feelings.				
	The Nurses Note	s, dated 3/21/11 at 2:50				
		Met with direct care staff				
	l '	f 3/19/11. Resident has				
		alarm has been Dc'd				
		taff will use smaller lap				
		e is in w/c or recliner to				
	blanket."	ity of getting tangled in				
	Dialiket.					
	The Nurses Note	s, dated 3/23/11 at 12:40				
		Met with direct care staff				
	ĺ	veness of interventions				
		h fall of 3-19-11,				
	1 *	ng utilized and effective."				
	mici ventions bei	ng unitzed and effective.				
	The Post Fall Da	porting Form, dated				
	l '	M., indicated "Date of				
	fall: 04/03/11. Ti	, , , , , , , , , , , , , , , , , , ,				
	P.MObserved of					
	(unwitnessed)C					
	l ` ′	g on floor. Legs bent at				
		ot hit headChair				
		your evaluation, what				
		plan interventions to				
		•				
	preveni a ruture i	fall occurring? Monitor				

				(X2) MU	X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILI	DING	00		COMPI			
		155715		B. WING				04/13/2	011		
NAME OF I	DROLUDED OD GUDDI IED			<u>' </u>	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER				111 WES	ST CHURCH A	/ Ε				
LUTHER	AN COMMUNITY H	OME INC			SEYMO	UR, IN47274					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENC	CIES	\vdash	ID				(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED F	BY FULL	P	REFIX	(EACH CORRECTIV	PLAN OF CORRECTION VE ACTION SHOULD BE	-	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFOR	MATION)		TAG		ED TO THE APPROPRIAT FICIENCY)	E	DATE		
	closely"										
	In an interview w	vith the Assistant Di	rector								
		/12/11 at 9:00 A.M.,									
	· ·										
		m was sounding wh	ien								
	the resident fell of	on 4/3/11.									
	m 10/4/40 2 3										
		l care plan was upda									
		ude the intervention	_								
	"When res becon	nes anxious and gett	ting								
	up frequently inv	olve res in activity.	"								
	The Nurses Note	s, dated 4/4/11 at 10	0:20								
		'CNA reported res c									
	· ·	tle with transfers.	, 0								
			ntona								
		e sl [slightly] edema	itous								
		comfort with ROM									
]. Called MD office									
	report res c/o. Sp	oke with nurse (nan	ne).								
	Awaiting return of	call."									
	The Nurses Note	s, dated 4/4/11 at 11	:00								
	A.M., indicated "	'Met with direct car	e staff								
	to review fall of										
		then res becomes an	xious								
		eq [frequently], invo									
	• • •										
	i nei in activity- in	place and care plar	meu.								
	Tel. Ni Ni	. 1.4.1 4/4/11 + 2	20								
		s, dated 4/4/11 at 3:									
		X-ray of R [right] a									
	received from (na	ame). This does sho	w a								
	subtle chip fx [fra	acture] of the R infe	rior								
	tip of medial mal	lleolus with minima	l								
	displacement"										
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete	Event ID: TF	EX11	Facility I	D: 000347	If continuation sh	neet Pa	ge 74 of 113		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	HOME INC		1	OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Nurses Note A.M., indicated to review interverse becomes anxious and down, involvintervention utility. The Post Fall Re 4/7/11 at 11:00 A fall: 04/07/11. To A.Mwas in bed with back against siderail (top)- on (V) shaped skin arm. Approx [ap [by] 0.2 cm. Sca [bleeding]Sum contributing to farecent fall with it involving R infermalleolus with m Removed ace with bed. Attempting on your evaluation plan intervention from occurring? when in bed" The 10/14/10 fall on 4/7/11 to incl. "Nonskid socks to the common of the contribution of t	es, dated 4/6/11 at 10:00 "Met with direct care staff ention of when res and attempting to get up we res in activities, ized and effective." Exporting Form, dated A.M., indicated "Date of time of fall: 11:00 di sleeping. Found on floor est bed- one hand on the hand on bedside table tear L [left] lower outer proximately] 0.5 cm x ant amt [amount] bldg timary of factors all: weakness continues, injury subtle chip fx					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
		A. BUII	LDING	00	04/13/2		
		1337 13	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		1	DUR, IN47274		
					7013, 11417271		(X5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	EACH CORRECTIVE ACTION SHOULD BE	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
	indicated a score	of 14					
	The Post Fall Re	porting Form, dated					
	·	M., indicated "Date of					
	fall: 04/09/11. Ti	-					
	PMDoes the Re	esident have a history of					
		? last 4-7-11No					
	1 *	Summary of factors					
	11	all: Res sitting in w/c next					
		ed [medication] cart.					
	, ,	in w/c and leaned over as					
	if to p/u [pick up] something from floor.					
		c landing on floor on					
	buttocksBased	on your evaluation, what					
		plan interventions to					
	_	fall from occurring? 1.					
	l -	e to nurses station as					
	_	in w/c; engage res in					
	some activity wh	ile in w/c to occupy					
	mind"						
	The 10/14/10 fall	l care plan was updated					
	on 4/9/11 to inclu	ade the intervention of					
	"Keep close to nu	urses desk when up in					
	w/c- engage in ac	ctivity to occupy mind."					
	The fall risk asse	essment, dated 4/9/11,					
	indicated a score	of 16.					
	2. Resident #61	was identified on the					
	initial tour of the	locked dementia unit, on					
	4/11/11 at 9:30 A	.M., by LPN # 19, as					
	having had recen	t falls and a hip fracture,					
	requiring an aları	ming floor mat, chair					
	clips and preferre	ed to stay in her room					
	most of the time.	The resident was					

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Event ID: **TEEX11** Facility ID:

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PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO			(X3) DATE	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. I	BUILDING	00		COMPL	
		155715	B. V	WING			04/13/2	U11
NAME OF I	PROVIDER OR SUPPLIER	R		I	DDRESS, CITY, STA			
					ST CHURCH A	VΕ		
	AN COMMUNITY F				UR, IN47274			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEI	TELENCT)		DATE
		2/12 at 9:00 A.M. lying in						
	bed in her room. All alarms were in place							
	and turned on.							
	Dazidant # Clla a	aliminal manaral array						
		clinical record was						
		1/11 at 10:30 A.M. The						
		imum data set assessment						
	l '	/11/11, indicated the						
		rerely cognitively						
		ed assistance with bed						
		ers and ambulation and						
		ncontinent of urine.						
		transitions and walking,						
	was not steady, t	the resident was only able						
	to stabilize with	human assistance while						
	moving from sea	ated to standing and						
	moving on or of	f the toilet. The resident						
	had fallen since	the last assessment, with						
	no injuries.							
	1 1	ated 10/1/10, included the						
	l -	ent at high risk for falls						
		ip and right groin, pelvic						
	area, updated 9/2							
	5/15/2008, FALI	L 11/16/10 at 1225 a.m."						
	Approaches incl	uded: "side rails to assist						
	with transfers an	nd bed mobility, non skid						
	foot wear with tr	ransfers and ambulation,						
	ambulate with as	ssist of 1-2 assist, walker						
	and gait belt, kee	ep room free of clutter, let						
	res(resident) feel	l in control, clip alarm						
	while up in chair	r, 11/3/10 bed against wall						
	1 ^	eside bed, 11/16/10						
		at all times, check sensor						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ST CHURCH AVE		
LUTHER	AN COMMUNITY H	HOME INC		1	OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	connections on f	loor senor, make sure					
	plugged in and a	ll the way, 2/17/11					
	anti-roll back de	vice on wheelchair,					
	3/30/11 staff to a	assist resident into bed					
	after supper."						
	l martin supplies						
	A fall risk assess	sment, dated 8/24/10,					
		ident was at a high risk of					
		soriented at all times, with					
		e past 3 months. A fall					
		dated 2/16/11, indicated					
	life resident was	at a high risk of falls.					
	A nurse's note d	lated 8/24/10 at 1:15 p.m.,					
	· ·	to (residents room) to					
		theterize)Resident was					
	1	elchair next to bed,					
		athroom. Door was					
		sident in sitting position					
		st wall with legs spread					
		asked if she hit her					
	head-stated that	she did initiating bed					
	and clip alarms f	for safety"					
	A nurse's note, d	lated 8/25/10 1 p.m. "Late					
	entry for 8/22/10	at 3:00 A.M., resident					
	found on floor in	n training room, resident					
	stated she went i	nto the basement to take					
	a nap, resident w	vas assessed and no sign					
	_	resident was assisted back					
	to bed"						
	During an interv	riew with the facility					
	_	on 4/12/11 at 11:00 A.M.,					
	·	<u> </u>					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		<u> </u>	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	she indicated the should have been indicated staff we resident had falle on the floor. A nurse's note, do indicated: "CNA assistant) called noted at 12:25 A.M. Reside with her hear bed. Alert and colooking for my begot here'" A Post Fall Repoor "2/15/11 4:00 P.M. 8/24/10 and 11/1 floor in residents cause-lost balance incident was: am to/from bathroom skid socks, what in use-floor mat a wheelchair was of status of resident falls-incontinence contributing to favomit on bed/shid unassisted-intervanti-rollback devices."	training room door locked. She further ere not sure if the en on 8/22 or laid down ated 11/16/10 5 A.M. (certified nursing nurse to resident's room es lying on floor on right d next to roommate's onfused. stated 'I was abyI don't know how I rting Form indicated: M., previous falls on 6/10, observed on the room, probable e, the activity during the bulating in bedroom or n, footwear-slippers, non mechanical devices were alarm, bed rails-2, on other side of room, at time of e, summary of factors all- incontinent of bowel, rt getting up from bed		TAG	DEFICIENCY)		DATE
		ants to use wheelchair."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/13/2	LETED
	PROVIDER OR SUPPLIER		111 WE	ADDRESS, CITY, STATE, ZIP CO ST CHURCH AVE DUR, IN47274	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated "Resident of room (not her tears. No outwar can abduct and a problem. No population of left leg pain. given at this time would like x-ray. The room the residents room wopposite hallway station. The post fall reperson of falls, observed room (not her owstrength/weakness incident was -amher room), gettind devices in use-cheak device, resident has incident has incident was notified 3/29. Summary of fact Resident has incident was incident was resident has incident was notified 3/29.	A.M. to be on the hallway e nurses station, the vas observed to be on the vas observed to be on the vas observed to the left of the nurses orting form indicated: M. resident had a history of the orting form resident's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) MU: A. BUILI		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155715	B. WING			04/13/2	011
NAME OF 1	PROVIDER OR SUPPLIEI	- {			DDRESS, CITY, STATE, ZIP CODE	-	
LUTUED		IOME INC			ST CHURCH AVE		
	AN COMMUNITY F				UR, IN47274		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		n wheelchair to bed by					
	self, future interventions-redirect when						
	needed."						
	Nurse notes, dat	ed 3/30/11 3:30 A.M.,					
	indicated "Resid	ent showered with assist					
		right elbow-purple bruise,					
	1	al forearm proximal to					
		rple bruise .5 cm right					
		aspect 3-4 cm 4 red					
		tal unopened, right upper					
	_	t above knee, small purple					
	1	es, ADON (assistant					
		ng), MD notified.					
	Resident comp	plains of pain in left leg"					
	Nurses notes dat	red 3/30/11 8:40 A.M.					
		plaints of pain left lower					
	extremity given	-					
	Hydrocodone 7.	5/500 orally at this time.					
	CNA (certified r	nursing assistant) reported					
	resident cried ou	it in pain when attempted					
	am care to attem	pt care at a later time"					
		licated the physician					
		1 on 3/30/11 at 12:45 p.m.					
	•	ay order. Nurses notes					
		ay was taken with results					
		ich included an acute					
	fracture of left h	-					
	displacement, ".	raxed results to					
	physician"						
	During interview	w with the Director of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	C		111 WE	ST CHURCH AVE		
	AN COMMUNITY H				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIVE ACTION			
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILIACI)		DATE
	1	/11 at 10:00 A.M., she					
		ident's alarms did ring on					
		0/11, before the fall. She					
		entation was lacking as to					
		m rang on 11/16/10, but					
		d prior to the start of the					
	shift the fall occi	urred on.					
	3. Resident #98	was identified on the					
	initial tour of the	e locked dementia unit, on					
	4/11/11 at 10:15	A.M., by LPN #19, as					
	being a high risk	for falls, requiring a					
	wireless sensor v						
	wheelchair, bed	and floor mat. Resident					
	#98 was observe	ed on 4/12/11 at 8:30					
	A.M. sitting in h	is room with his spouse,					
	_	ho resides in the room					
	•	ent #98 was sitting in a					
		alarming chair cushion					
	and an alarming	_					
		F					
	Resident #98's c	linical record was					
	reviewed on 4/1	1/11 at 11:00 A.M.					
	Diagnoses include	ded but were not limited					
	to: dementia and	d senile Parkinson's					
	disease.						
	A history and physical, dated 1/8/11,						
		: He is alert. He has					
	difficulty answer	ring any questions. He					
	does not seem to	have good recollection					
	of recent events. Per his primary care						
	physician he is having increasing memory						
		g medications regularly,					
	· ·	ntments. His wife's					
	· ·						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/13/2	LETED	
NAME OF 1	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN COMMUNITY I	HOME INC		1	ST CHURCH AVE DUR, IN47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	memory issues are advanced to the point that she gets lost driving through town"						
	that she gets los	t driving through town"					
	The admission N	MDS(minimum data set)					
	assessment, date	ed 1/22/11, indicated the					
	resident was into	erviewable, required					
		bed mobility, transfers,					
	1	ssing and was frequently					
		rine. The assessment					
		sident had a fall in the past					
	1 ^	ast 2 to 6 months. His					
		steady and he was only himself with help with					
		ated to standing, walking,					
	_	If the toilet or from surface					
	to surface such a						
	to surface such t	as oca to chair.					
	The admission a	assessment detail report,					
	dated 1/16/11 at	7:35 A.M., indicated for					
	1 * '	ent was "disoriented at all					
		n past 3 months." The					
	1 ^	assessment, indicated the					
		t able to ambulate					
	1 1	gait was unsteady, could					
		from bathroom on own, ne and bowel, had					
		ns and or confusion and					
		awareness and/or					
	impaired decision						
	impaired decision	,					
	The falls risk as	sessment, dated 2/13/10 at					
	7:45 P.M., indic	ated the resident was at a					
	1 -	s, related to intermittent					
	confusion, falls	in past 3 months,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUII	LDING	00	COMPLE	
		155715	B. WIN	G		04/13/20)11
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WINE OF I	NO VIDER OR GOLLEIER			1	ST CHURCH AVE		
LUTHER	AN COMMUNITY H	OME INC		SEYMO	DUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	· ·	balance problems while					
		k assessments, dated					
		3/1/11, 3/19/11, 3/21/11,					
		the resident at high risk					
	for falls and had	intermittent confusion.					
		ladder assessment, dated					
	· ·	d the resident was					
		required extensive					
		ransfers, had urge					
	` '	quires resident needing to					
	~	e urge)." The assessment					
	1	ed to indicate if the					
		or unable to participate					
	ı	timed voiding program.					
		with the DON on					
	4/13/11 at 9:30 A	A.M., she indicated the					
	resident had beer	n continent at the time of					
	the assessment.	She indicated staff would					
		s when the resident was					
	taken to the bath	room.					
	_	ated 1/16/11, included					
	"fall/safety risk"	1/16/11-keep call light in					
	reach of resident,						
	reminders to use	call light, reminders for					
	1	sk for assistance with					
	mobility, assess i						
		nd non skid soles,					
	therapy as needed	d, fall safety/risk					
	reminder in resid	lents room, 1/17/11 bed					
	sensor, chair sens	sor, 1/24/11 change					
	rooms to closer to	o nurses station, 1/29/11					
	15 minute checks	s, do not leave in					

	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED
	F PROVIDER OR SUPPLIED			STREET A	ST CHURCH AVE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	bathroom alone. 2/13/11, risk for 3/19/11, fall 3/2 interventions of remind and coach or nurse for help turning off alarm sensor in recline toilet at bedtime free, 3/21/11 keed door partially open encourage res to after supper, 4/2 sensor in place i The CNA assign resident indicate spouse to summ ambulationkeekeep resident from after supper and go to bathroom, A Post Fall Report The Fall Report The CNA in the company of fact of fall 1/2 and history of floor in resident bed, non skid so devices in use-bupper, low bed a summary of fact resident sleeping out of bed to go	Another problem, dated falls, Fall 2/13/11, fall 1/11 included " 15 minute checks, the resident to summon aid to, discourage spouse from the state of the state o					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
NAME OF I	DDOMINED OD GUIDDI IEI	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			111 WE	ST CHURCH AVE		
	LUTHERAN COMMUNITY HOME INC				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CO			
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
	1	as on 1 knee by side of					
	1	ited self off floor very					
		demonstrate to staff what					
	1	ne slid of bed.'" Fall					
	1 ^	mentation indicated:					
	1 ^	"res continues to get up					
	1	ghout the day today"					
		vill move res Monday or					
	1 ^	or" "1/24/11 250 p.m.					
	1	tting up without calling					
		nd interventions "moved					
	to room (closer t	to station)."					
		2/11 .: 20.11 6.50					
		3/11, time of fall 6:50					
		ry of falls, Resident's					
	1 1	do you think you					
		bathroom on his					
	1	r had basket sitting on it					
	1	t up paper from floor lost					
	1	on right side, observed on					
	the floor, locatio	n bathroom, probable					
	1	ost strength, other cause-					
	short staffed, ac	tivity during-ambulating					
	to and from bath	room, what mechanical					
	devices-had bash	ket sitting on alarm-in off					
	position, unstead	ly gait, based on					
	evaluation what	are possible care plan					
	interventions to	prevent a future fall from					
	occurring-couns	eled spouse and resident					
	on importance o	f alerting staff for					
	assistance; also a	asked that she not turn off					
	alarms, she adm	itted to turning off chair					
	1	5 minute checks, is					
		15 minute checks."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/13/2	ETED
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
				1	ST CHURCH AVE		
	RAN COMMUNITY F			SEYMO	DUR, IN47274		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
							21112
	"2/14/11 6:00 PI	M has history of falls,					
		bathroom and missed					
		ed on floor in resident's					
		but missed chair,					
	· ·	nd from bathroom, what					
		ces were in use - chair					
	alarm, has in wh	eelchair not used turned					
	off by wife, floo	r mat by chair. Based on					
	your evaluation	what are possible care					
	plan intervention	ns to prevent a future fall					
	from occurring-a	additional sensor-wife					
	takes (resident n	ame) from wheelchair to					
	bathroom, bathro	oom to recliner without					
	telling staff."						
	2/20/11 11:40						
	1	o.m. getting up to use yed on floor in resident's					
	1	mbulating in bedroom,					
		nat alarm-both sensors					
		physical status at time of					
	1	e, summary- spouse					
		tanding position from					
	_	came out in hallway and					
	1	nelp. Res was on all 4's on					
		ors were turned off.					
		tion, what are possible					
		entions to prevent a future					
	_	couple or devise a					
	different type of	sensor that can't be					
	turned off by spo	ouse"					
		Documentation, dated					
	2/20/11 at 1140	p.m., indicated the					
	resident was mo	ved closer to the nurse's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		ĺ	LDING	NSTRUCTION 00		ESURVEY LETED 2011	
NAME OF 1	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE	_	
LUTHER	AN COMMUNITY I	HOME INC		1	ST CHURCH AVE DUR, IN47274		
(X4) ID	SUMMARY	MMARY STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	station and wou	ld be toileted at hour of					
	sleep.						
	indicated: "Note opened door at 3 partially lying of sensors to floor tucked in pocket tried to recline ustated that chair lifted footrest in asked res to plea pulled door 1/2 to not close come "3/1/11 9:45 P.M why do you thin finished with his urinal to him and Incident- observation out of chair, mediated to sensor to the sensor of the	M. Resident response to ak you fell? Wasn't s business-wife giving d tripped over chair. red on floor in resident's ag in the bedroom, getting chanical devices-chair and					
	•	summary- Resident					
		se urinal, tripped over					
		him, based on evaluation, le care plan interventions					
	1 ^	re fall from occurring?					
	_	fe to ask staff for help, use					
		ensor alerts on, keep room					
	clutter free."						
		0 P.M., Resident's do you think you fell? I					

		X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MUI		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		ll		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		111 WE	ST CHURCH AVE		
	RAN COMMUNITY F			SEYMC	OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRI			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		ed tried to stand up to					
	1	side of bed. observed on					
	floor, resident's	-					
	1 -	ss, getting out of bed to					
	urinate, unsteady	gait, uses					
	walker,summary	-no bed sensor to indicate					
	activity, possible	e care plan					
	interventions-ins	stall bed sensor"					
	"3/21/11 4:15 P.	M. wife involved with					
	care of resident's	s care, observed on floor,					
	ambulating in be	edroom, ambulating					
	to/from bathroon	n, bear feet left foot, chair					
	alarm turned off						
	1	ime of fall, summary-					
	1	to/from restroom without					
		one sock on and one sock					
		on floor-no pants on.					
	1	want to ask for staff help,					
	1	_					
	1	f sensors possible care					
	1 ^	ns- encourage resident to					
	stay in lounge ar						
	1 *	esident if he needs to use					
	restroom."						
	 "4/2/11 4·40 P N	1. Resident's response to					
		ng to my wheelchair.					
	1	or, residents room,					
		edroom, reaching for					
	1	_					
	1 -	floor mat alarm were in					
	1	all resident incontinent,					
		ors contributing to					
	1 -	arm sensor was removed					
	by his wife. res g	got up from chair legs					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/13/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	were weak and h interventions to p chair pad sensor frequently, fr	e fell on floor, possible brevent future falls- keep in place in recliner, check ent therapy" The fall tentation, dated 4/2/11 at red interventions of keep d in place in recliner, removes sensors-staff retance of asking for 1 5:30 a.mspouse mor pad from next to was under bed, asked restree in place for safety' therapy note, dated d "Patient has not multiple falls and ment-Patient presents trength, Range of tolerance, balance and recing ability to participate and functional er: sit to stand-The patient ransition from sit to moderate assistance with		IAG			DATE
	indicated "social resident regardin fallinformed re	service spoke with g his most recent s that he needs to use his nursing staff can assist					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	E SURVEY PLETED //2011
	PROVIDER OR SUPPLIER		111 WE	ADDRESS, CITY, STATE, ZIP CO EST CHURCH AVE DUR, IN47274	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	reviewed on 4/11 Diagnoses include "dementia." The assessment, dated resident was cognisk assessment, the resident was The facility lacked provided adequate Resident #98 from and ambulate on resulting in falls	de but are not limited to admission MDS de 2/6/11, indicated the nitively impaired. A fall dated 1/31/11, indicated disoriented at all times. The devidence of having the supervision to keep meattempting to transfer his own to the bathroom and had not updated the ease the amount of times				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Each resident's drug regimen must be free F0329 from unnecessary drugs. An unnecessary SS=D drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. F 329 Drug Regimen Is Free F0329 05/10/2011 Based on record review and interview, the From Unnecessary DrugsIt is the facility failed to ensure policy of this facility to ensure that nonpharmaceutical measures were each resident's drug regimen is attempted to control behaviors prior to the free from unnecessary drugs I. Corrective Action For Resident administration of drugs, in that Resident Affected: An interdisciplinary team #99 was administered Ativan (anti anxiety review was completed on medication) and Haldol (an antipsychotic) Resident #99 on April 28, 2011 to to control behaviors without evidence of review her care, identify individualized interventions that alternate interventions having been would avoid the use of implemented, for 1 of 8 residents unnecessary drugs, and to reviewed with as needed medications provide appropriate activities and ordered, in the sampled of 21. diversion. This individualized care plan was communicated to staff through the behavior care Findings include: plan and through staff education. II. Other Residents Having The 1. On the initial tour, on 4/11/11 at 10:15Potential To Be Affected: All

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TEEX11

Facility ID:

000347

If continuation sheet

Page 92 of 113

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155715 04/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 111 WEST CHURCH AVE LUTHERAN COMMUNITY HOME INC SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE A.M., LPN # 19 indicated Resident # 99 residents with behaviors have the potential to be affected. An had dementia, has had several falls and a interdisciplinary team review was recent fracture. completed on all residents who exhibit behaviors on April 28, 2011. (Attachment titled Behavior The clinical record for Resident # 99 was Care Plan Audit Tool). An reviewed on 4/11/11 at 11:45 A.M. The individualized care plan and record indicated Resident # 99 had interventions were developed for diagnoses that included but were not residents that can be used to limited to dementia and anxiety. The avoid the use of unnecessary drugs. These care plans are MDS [minimum data set] assessment, available to all staff in a binder at dated 1/20/11, indicated Resident # 99 the nurses station.III. Systemic had impaired cognition, and had no Changes and Steps To Ensure behaviors. That The Deficient Practice Does Not Recur: Behavior care plans will be discussed and updated at A Physician order, dated 10/15/10, each care plan meeting and as indicated "...PRN Ativan 0.5 mg Q necessary on the nursing unit. Behavior care plans will also be [every] 8h [hours] po [by mouth] reviewed in the behavior anxiety." management meetings at least every six months and as The Nurses Notes, dated 10/20/10 at 7:30 appropriate. Mandatory P.M., indicated "Res back at nurses desk education will be held on May 4th and 5th. 2011 with all nurses and with purse in hand demanding to talk with certified nursing assistants on this daughter. Told res she had spoken with plan of correction. (Attachment her just a few minutes earlier and res did titled Required Education Nursing not recall conversation. Stated that she Staff). Nurses will be educated that the interventions that are would call her dad to come and pick her attepted prior to the up if (daughter's name) couldn't. administration of medication Unsuccessful with 1:1 [one on one] gave i should be documented in the [one] Ativan (antianxiety medication) 0.5 nurses notes. An audit tool was developed to be used by the mg at this time for increased anxiety and Director of Nursing or her nervousness..." designee to ensure that all individualized interventions and The Nurses Notes, dated 10/22/10 at 5:00 behavior care plans are followed prior to the administration of A.M., indicated "Awake and at nurses

STATEMENT OF DEFICIENCIES (X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155715	B. WIN			04/13/2011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	ST CHURCH AVE		
	AN COMMUNITY H	HOME INC			OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	•	TAG		DATE	1
	·	to 3:30 am. Dressed self			medication. (Attachment title Unnecessary Drugs Audit	ea	
		round wanting to leave.			Tool).IV. Monitoring of Corre	ctive	
	1	king to go home, call			Action: Audit results will be		
	daughter, call ne	phew. Redirected without			reviewed by the Quality		
	success. Gave A	tivan 0.5 mg at 2:37 am.			Assurance Committee mont		
	Went to bed at 3	:30 A"			for six months. If the appropriate care and documentation is	riate	
					care and documentation is completed 100% of the time		
	The Nurses Note	es, dated 10/22/10 at 6:30			monthly monitoring will be		
	P.M., indicated '	'PRN [as needed] Ativan			stopped and random audits		
	0.5 mg given po	[by mouth] at this time			occur. A sample size of 25%	ś will	
	1 00 1	tation. Wanting to go			be completed monthly. If	-4	
	·	asking to call family			opportunities for improveme identified through the randor		
	l -	talk with family."			audits, a full audit will resum	l l	
	even mough ara	taik with family.			after six months of audits, 10	l l	
	The Nurses Note	es, dated 10/22/10 at			compliance continues, audit	· .	
		cated "Resident into			will stop. The results of all a will be reviewed by the Qual		
	· ·	s clothing/pictures and			Assurance Committee mont	•	
		tems away. Daughter					
		th res first then talked					
	· ·	ghter requested that					
		ame) to see if res could					
	get something el						
	~ ~ ~	ter called on call Dr					
	l ` ′	der for Haloperidol					
		nedication) 5mg/ml Give					
		[intramuscular] for					
	agitation. Gave l						
	· -	th compliance from					
		giving medication/IM					
		ip laminated copy of					
		el that was roommate's.					
	Writer took away	y"					
	A Physician orde	er, dated 10/22/10,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE : COMPL 04/13/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	 	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN COMMUNITY F	HOME INC		l	PUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		Haloperidol 5mg/ml (2.5 ttion. May give other half if still agitated."					
	P.M., indicated '	es, dated 10/23/10 at 6:45 'Res anxious and en but not effective in					
	The Nurses Notes, dated 10/23/10 at 7:00 P.M., indicated "Gave Ativan 0.5 mg for anxiety"						
	The Nurses Notes, dated 10/24/10 at 8:30 P.M., indicated "Res back and forth from recliner to room to nurses desk wanting telephone book or wanting to talk to her dau [daughter], grandson, sister or brother etcunsuccessful in re-orienting and 1:1 sessions. Repetitive questions and nervous behaviors. Gave Ativan 0.5 mg i po for anxiety"						
	indicated "Haldo	er, dated 10/24/10, ol 5mg/ml give 2.5 mg in may give 2.5 in 4 hour if ."					
	11:35 P.M., indi agitated, refusing nurse. Wanting t come and get he	es, dated 10/24/10 at cated "Res anxious and g redirection yelling at o go home wanting dau to r. Interrupting report, recliner. MD notified					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUILI	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE UR, IN47274	1	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	gave order for Hamedication) 5 mg agitation now. Mg if remains anxious A Physician order indef [indefinited Ativan 0.5 mg per DC Ativan q8 how A Physician order indicated "Haldon [times] 5 days for The Nurses Note 12:35 A.M., indiging IM at 11:50 If awake agitated a demanding staff to come and get who was sleeping her and woke her in recliner" A Behavior/Inter Record, dated 10 "Behavior 1. Aging go home. Intervented in the same agitated and the same and the same and the same and works and the same and works agitated and works	aldol (antipsychotic g/ml give 2.5 mg IM for fay give 2.5 mg in 4 hours as and agitated." Ativan 0.5 mg po BID y] for anxiety. May give D BID PRN for anxiety. PRN." ar, dated 10/25/10, 11 mg IM a 4 hr PRN x r agitation." s, dated 10/25/10 at cated "Gave Haldol 2.5 PMContinues to be		TAG		NTE	DATE
		s, dated 10/27/10 at 4:30 'Res awake at 11:15 PM					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUII	LDING	NSTRUCTION 00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	roaming in halls thru roommate's clothes carrying off unit. Wanting encourage to lie Gave PB and J [p and 240 (8 ounce continued to be rand asking to lead po at 1:39 AM) The Nurses Note (located between and 10/28/10 10: "Anxious unable bed in and out of redirected d/t [du Asked nurse for Is the medicine in medicine helps hamg at 12:40 AM A Physician order indicated "D/C 8 mg d/t [due to] of [bedtime] dose a PRN does to be ganxiety." The Nurses Note P.M., indicated "resident this after sident this after sident this after sident sident sident sident safer	and others rooms going belongings. Packing around. Attempting to get to go home. Tried to down in bed, recliner. Deanut butter and jelly] are milk consumed both edirected in others rooms we. Gave Ativan 0.5 mg around. Since the toler of the second of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MU A. BUII		ONSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED	
		1557 15	B. WIN		PRESIDENT OF THE CORP.	04/13/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME INC			DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	decreased to onl	· · · · · · · · · · · · · · · · · · ·	-	IAG			DATE
		RN. Called (name) at Dr					
	1	d made aware of family					
	request. N.O. [no	·					
	1 ^ -	AM dose of Ativan 0.5 mg					
	1 2	Continue HS dose and					
		es at q [every] 6 hours as					
	needed for anxie						
	The Nurses Note	es, dated 10/29/10 at 1:00					
		"Awake wandering halls					
		s into roommate's					
	belongings in dr	awers. Very anxious at					
	11:15 PM shift o	change past several nights.					
	Packs and carrys	s (sic) her belongings					
	around wanting	to go home wants staff to					
	call dau nephew	to pick her up. Res at					
	nurses station an	d med carts demanding to					
	get her a bag for	belongings. Attempt to					
	redirect distract	by offering food fluid					
		search 1:1. None of these					
		ve been successful this					
		mg po at 11:47 PM for					
	anxiety/agitation	1"					
		es, dated 10/30/10 at					
		icated "Resd [resident]					
	1	restless up/down going					
	1	ntering other resd					
	1	ing through roommate's					
		llway and back to other					
	I	ious becoming upset.					
	1	given for increased					
	anxiety/agitation	1."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/13/2	ETED	
	PROVIDER OR SUPPLIEE		•	111 WE	.DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE IUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	A.M., indicated in trash can, here Coming to hall a up papers any ite glasses books. H [breakfast] movi Unable to redire grandpa and my monitor." The Nurses Note A.M., indicated above behavior I distractions but to 0.5 mg po given The Behavior/In Record, dated N "Behavior 1. A. wanting to go heredirect. 1 on 1, activity, return to give fluids, chan temperature, bace PRN Ativan, given The Nurses Note A.M., indicated station at 11 PM report. Continue	es, dated 10/30/10 at 8:00 "Continues nonstop with nave tried above res not re-directed. Ativan at this time." tervention Monthly Flow ovember 2010, indicated agitation B. yelling C. ome. Intervention codes-refer to nurses notes, o room, toilet, give food, ge position, adjust room k rub, call family, give					
	· ·	g into cups and med cups					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIE		р. wих	STREET A	ST CHURCH AVE	ļ.	
	RAN COMMUNITY F			<u> </u>	OUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	cards. Was const offered food and putting on pajarn grandpa and daddining room call Door was then led down hall past hacross hall." The Nurses Note A.M., indicated 3:03 AM" The Nurses Note A.M., indicated intrusive, unredistation until 2:30 i at 12:20 AM, in be anxious, refusor bed. Rummag station. In bed at in bed since 2:30 The Nurses Note A.M., indicated multiple x's [tim I've got a doctor Where is my pook keys? I've got to one] offered whice continued to be somewhere.	strying to touch med antly redirected, 1:1, affluid assisted with has. Wanting to call her as. Wanting to call her as. Wanting to call her as. Found res at door to light on above door. Ocked. Was also walking her room, entered res room as, dated 11/1/10 at 3:40 as, dated 11/2/10 at 5:30 as, dated 11/2/10 at 5:30 as, dated 11/2/10 at 5:30 as anxious, agitated, rectrable (sic). At nurses and Am and Am Am and Am an					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/13/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274	10 11 10/2	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) an given at this x."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	The Nurses Note A.M., indicated 'into nurses statio rooms entire shift did several intervineffective. Gave [by mouth] at 3:1 Continued to go residents were slesseveral residents belongings some attempted to hit to several times too yelling this is my can go wherever continued entire from 11p - 7 a. Dres behavior, DO notified. Continue wandering in resummer of the Nurses Note P.M., indicated 'other resident's regoing through clausitated when staraises voice and shouse! Refused of at this time: Klore	s, dated 11/5/10 at 6:50 'Res has been intrusive n into all but 2 resident's it. Unredirectable (sic) yentions which were e Ativan 0.5 mg i [one] po 17 AM was ineffective. into rooms when eeping. Awakened attempting to take res's res became upset this resident. Intervened k res out of room. Was y house this is my room I I want. This behavior shift res did not sleep eayshift nurses notified of en [Director of Nursing] hees to be awake					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIE		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUME	BER:	A. BUILI	DING	00		COMPI	
		155715		B. WING				04/13/2	U11
NAME OF F	PROVIDER OR SUPPLIER					ADDRESS, CITY, STA			
						ST CHURCH AV	/E		
LUTHER	AN COMMUNITY H	OME INC			SEYMO	OUR, IN47274			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIEN	ICIES		ID		LAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED		P	REFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFO		•	TAG	DEF	ICIENCY)		DATE
		s, dated 11/8/10 at							
		'Res sitting in recli							
		get out and go hom							
		ral times, clip alar							
	_	e had to get home.	-						
	1:1 time, distracted with folding clothes,								
	food, fluid, reading. Interventions								
unsuccessful continued 1:1 with res. In									
	hallway, draggin	g blankets, purse a	nd						
	house slippers at	tempting to go into	res						
	rooms. Yelling at	t staff awaking (sic	·)						
	residents in rooms. Ref [refused] to sit or								
	lie (sic) in bed. A	Attempted to give A	tivan						
	in ice cream refu	sed. Gave Haldol 2	2.5 mg						
	IM [intramuscula	ar] in L [left] butto	cks at						
	-	ole to sit in recliner							
	1:30 AM"								
	A Physician orde	er, dated 11/8/10,							
		dol 0.25 mg (1/2 ta	ab-						
		D behavior abnorm							
		Reduce Haldol IM							
		PRN max 3 doses i							
	24h."	THE CHILD GODGE							
	2								
	A Physician orde	er dated 11/9/10							
	,	Klonopin 0.5 on h	old- 2						
		today with one or	<u>.</u>						
	2assist. 3. Hold	-							
	۵۵55151. ع. 11010	i aii iiicu- 24ii.							
	A Physician orde	er, dated 11/10/10,							
		Klonopin 0.5 mg j	20						
			•						
	BID. 2. Klonopin 0.25 mg po now and then at 8p tonight. 3. Then Klonopin 0.25								
		•							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete	Event ID: TE	EX11	Facility 1	ID: 000347	If continuation sh	neet Pa	ge 102 of 113

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715			LDING	00	04/13/2	
		1007 10	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN COMMUNITY H	OME INC		1	OUR, IN47274		
			-		1		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	mg no at 8A and	4p anxiety. 4. Hold					
		aldol until further					
	1 ^	D. Resume all other					
	previous meds."						
	previous meds.						
	A Physician orde	er, dated 11/10/10,					
	1 *	y use Ativan 0.5 mg q					
	l .	s] PRN [as needed]					
		naximum] 1 mg in 24 h.					
	2. One time dose	Klonopin 0.25 mg po at					
	8 pm tonight."						
	The Nurses Note	s, dated 11/26/10 at 2:10					
	P.M., indicated "	Pharmacists made					
	recommend (sic)	after behav [behavior]					
	committee met a	nd discussed res sleeping					
	during day and b	eing awake at noc					
	[night]. She freq	[frequently] disrupts					
	other res sleep at	noc and isn't easily					
	re-directed. Spok	te with pharm					
	[pharmacist] he s	suggested Melatonin 3					
	mg hs [bedtime]	to help realign her					
	` ′	le said studies have					
		lts when someone has to					
	_	es to adjust "clinically					
		no SE [side effects] or					
		is has been discussed at					
	length for this res						
		bility. Spoke with					
		re: above, she said she's					
		d her we will monitor res.					
	Updated Dr (nam	ne) waiting response."					
	The Behavior/Int	ervention Monthly Flow					

MAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REQULATORY) OR LSC IDENTIFYING INFORMATION) Record, dated December 2010, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
LUTHERAN COMMUNITY HOME INC (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Record, dated December 2010, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,			155/15	B. WIN			04/13/2	011
LUTHERAN COMMUNITY HOME INC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Record, dated December 2010, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,	NAME OF P	PROVIDER OR SUPPLIEF	3		1			
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back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,								
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help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,			-					
meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,		, , ,	•					
1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,			•					
room, toilet, give food, give fluids, change position, adjust room temperature,								
change position, adjust room temperature,		·	•					
back rub, call family, come/go back later."								
		back rub, call far	mily, come/go back later."					
A Physician order, dated 12/8/10,		A Physician orde	er, dated 12/8/10.					
indicated "DC [discontinue] Haldol 0.5								
mg BID [two times daily]. DC Depakote		-	-					
125 mg po [by mouth] at 12 N [noon] and								
6 p."		• • • • •						
		- r.						
The Nurses Notes, dated 12/31/10 at 6:00		The Nurses Note	es, dated 12/31/10 at 6:00					
P.M., indicated "Called dtr [daughter] to			, , , , , , , , , , , , , , , , , , ,					
ease anxiety. Pt [patient] very anxious and		· ·						
looking for a way out. Gave prn [as		_						
needed] Ativan."		_						
The Behavior/Intervention Monthly Flow		The Behavior/In	tervention Monthly Flow					
Record, dated January 2011, indicated			-					
"Behavior 1- agitation, yelling, wanting to		•						

AND PLAN OF CORRECTION ID.		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPLE	
		155715	A. BUII B. WIN			04/13/20)11
	PROVIDER OR SUPPLIER AN COMMUNITY H			STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE OUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWNENG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	go home. Interve	ention codes- redirect. 1					
	on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature,						
	back rub, call far	nily, have redirect. 1 on					
	1, refer to nurses	notes, activity, return to					
	'	e food, give fluids,					
		adjust room temperature,					
	· ·	nily, have her sweep,					
	' " '	ask family to come in.					
		ising meds. Intervention					
		1 on 1, refer to nurses					
		eturn to room, toilet, give					
	_	change position, adjust					
	room temperatur	e, back rub, call family,					
	come/go back lat	er."					
		s, dated 1/9/11 at 1:15					
	A.M., indicated '	'Up/down. Unplugging					
		ection, 1:1 ineffective.					
	Refused foods/flu						
		om (number) asking					
		d to clean. Refused to					
	· -	eeded] Ativan 0.5 mg					
	given at this time	e. Did accept in pudding."					
	The Nurses Note	s, dated 1/10/11 at 8:43					
		'Awake all morning					
		unit looking for glasses.					
	_	am alert bracelet cut off.					
	_	er so she can cut it off.					
	_	irect with sweeping					
	folding laundry e						
	1	that you won't cut this off					
		-					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/13/2	ETED	
		1007 10	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 17 1072	
NAME OF	PROVIDER OR SUPPLIEI	₹			ST CHURCH AVE		
	RAN COMMUNITY F				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
0	 	er. Gave Ativan 0.5 mg at					D.H.E
	this time."	ar. Suveriavan v.s mg ac					
	A Care plan, dated 1/12/11, indicated a						
	problem of "Rou	itine use of psychoactive					
	meds with poten	tial for side effects." The					
		ere "1. Administer meds as					
		itor for side effects such					
	as dry mouth, ur	•					
		potension, etc. 3. Report					
	side effects to MD."						
	The Nurses Notes, dated 1/13/11 at 4:00						
		"Res awake, wandering in					
	1	her's rooms at 11:15 P.M					
		ed food and fluids					
		a cup of apple juice and					
		es. Behavior escalated					
	when attempting	to redirect. Yelling at					
	staff and residen	t to get out of my house					
	now or I'm going	g to call the police. Went					
	behind recliners	and pulled electrical cord					
		V. Tried to push on TV					
	screen. Continue	ed to yell at CNAs. Went					
	1	ried to pull wreath off					
		ome back to recliners,					
	1	ed. Sat with res and					
		and seed magazine for					
	1	tivan 0.5 i [one] po [by					
	mouth] at 2:06 A	AM."					
	A Rehavior Man	agement Team Review,					
	1	ndicated "Summarize the					
	1	rrences. Include number					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<u> </u>	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE:	ETED
		155715	B. WIN	G		04/13/2	011
	PROVIDER OR SUPPLIER		•	111 WE	DDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE OUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	possible causes, precipitating and known). Review medications to in and any side effeteam recommends Behaviors Monit bossyness (sic), (occurrences/interprecipitating Face Psychotropic Meclonazepam 0.25 PRN. Recomment (Psych company [medication] chassessment to dedementia." The Nurses Note P.M., indicated "[management] te behav and becomere-direct. Has use mo [month]. Recompany name) is back from sick res while Dr (name) on this arwith (Psych come (Daughter name)	cts noted. Document lationsSummary- ored: anger, agitation, verbal aggression. Pattern erventions): almost daily. tors: unknown. dication and Care: at 6p, lorazapam 0.5 indation: Refer all to name), possible med inge, mini mental termine type of s, dated 1/27/11 at 12:00 Behav [behavior] mgmt am met re: res increased ing more difficult to ed Ativan 6 x [times] past					
	1 .wi., mulcated	At uesk past flour asking					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		ļ .	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIER			111 WE	ADDRESS, CITY, STATE, ZIP CODE ST CHURCH AVE DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	tears have tried of drink and snack, work. Becoming to (daughter nammin. Res crying. with me and requested for the Behavior/In Record, dated Few Behavior 1- aging go home. Intervet on 1, refer to nurse to room, toilet, go change position, back rub, call fair 1, refer to nurses room, toilet, given change position, back rub, call fair 1, refer to nurses room, toilet, given change position, back rub, call fair clean, organize, Behavior 2- Refice codes- redirect. notes, activity, refood, give fluids room temperatur come/go back lath. The Nurses Note A.M., indicated Has been going that are you in my hor	tervention Monthly Flow ebruary 2011, indicated tation, yelling, wanting to ention codes- redirect. 1 reses notes, activity, return ive food, give fluids, adjust room temperature, mily, have redirect. 1 on notes, activity, return to e food, give fluids, adjust room temperature, mily, have her sweep, ask family to come in. using meds. Intervention 1 on 1, refer to nurses eturn to room, toilet, give tenge position, adjust re, back rub, call family,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **TEEX11** Facility ID:

000347

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		l	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF 1	PROVIDER OR SUPPLIEI	₹		1	ST CHURCH AVE		
LUTHER	RAN COMMUNITY F	HOME INC		1	DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1	st on desk. Explain why					
	1	are in my house? Tried					
	talking 1:1 [one to one] with res. refused						
	Bfast [breakfast]	offered to dust furniture,					
	wipe tables etc N	No! I want an answer.					
	Gave Ativan 0.5	mg at this time."					
	1	tervention Monthly Flow					
	1	farch 2011, indicated					
	1	lling, wanting to go					
	home. Interventi	on codes- redirect. 1 on					
	1, refer to nurses	s notes, activity, return to					
	room, toilet, give	e food, give fluids,					
	change position,	adjust room temperature,					
	back rub, call far	mily, have her sweep,					
	1	Behavior 2- Refusing					
	1 ~	on codes- redirect. 1 on					
		s notes, activity, return to					
	1 '	e food, give fluids,					
		adjust room temperature,					
	1	-					
	back rub, can ra	mily, leave and try later.					
	The Nurses Note	es, dated 3/1/11 at 7:00					
	P.M., indicated '	'Resident up/down out of					
	1	throom 1:1 given without					
	1	ed PRN Ativan given at					
	this time."	en i i i i i i i i i i i i i i i i i i i					
	The Nurses Note	es, dated 3/6/11 at 9:16					
		"Restless all AM.					
	1	mom and phone #. Where					
	1	en bfast [breakfast] and					
	1	sic) in hall with staff.					
	1						
	Looked at remin	ece (sic) book with her.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
		IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155715	B. WIN			04/13/2	011
		1	D. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ST CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME INC		1	DUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	Gave her phone	book, paper and pen to					
	look up phone #. Toileted. Cont [continue] to be restless. Becoming sl [slightly] teary now. Gave Ativan at this						
	time."						
	l time.						
	The Nurses Note	es, dated 3/7/11 at 8:15					
		'Res wants to call mom					
		es worried that a little girl					
		Staff reassures that no					
	_	been taken. Res has been					
	1 ^	ning. Res has been folding					
		s been taken to restroom.					
	1:1 given. Fluids	s offered but resident					
	refused. Phone b	book given to resident					
	look at. PRN Ati	ivan given at this time."					
		1 / 12/0/11 / 620					
		es, dated 3/9/11 at 6:30					
		'Resident up and down in					
	_	to ambulate with					
		ecame restless, agitated.					
	Offered food and	d fluids- refused. Offered					
	toileting which v	was accepted but res still					
	restless. Became	anxious wanting to go					
	see her parents,	sister and brother (all					
		l and shaky. Gave i [one]					
		o at this time. Will					
	monitor effective						
							
	The Nurses Note	es, dated 3/14/11 at 6:00					
		"Fall risk continues. Was					
	1	xious, shaking and unable					
	1	Fusing food and fluids.					
		mg i po at 3:06 AM, eff					
	Jave Auvali U.S	mg i po at 3.00 Aivi, eli					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ļ .	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155715	B. WIN	G		04/13/2	2011	
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 111 WEST CHURCH AVE SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	SHOULD BE COMPLETION		
	P.M., indicated "following: 1. Res Ativan 0.5 mg i pagitated not more 2. Dau (daughter changed to 0.25 magitation- not me hours due to cause many hours/shift this AM over photomaphore in the Nurses Note A.M., indicated '(name) to DC [dimg PRN change PRN for agitation 24 hours d/t over hrs/shifts" The Behavior/Int Record, dated Ap "Behavior 1- yellower home. Intervention 1, refer to nurses room, toilet, give change position, back rub, call far clean. Behavior 2 Intervention code to nurses notes, a	s, dated 3/16/11 at 3:30 Faxed Dr. (name) the sident has an order for po q [every] 2 hours prn e than 1.0 mg in 24 hours.) would like order mg po q 2 hours prn pre than 0.5 mg in 24 ges over sedation for s. Spoke with dau (name) pone." s, dated 3/17/11 at 10:40 PNO [new order] per Dr. scontinue] Ativan 0.5 to 0.25 mg po q 2 hours an not more than 0.5 mg in resedation for many servention Monthly Flow port 2011, indicated alling, wanting to go on codes- redirect. 1 on notes, activity, return to be food, give fluids, adjust room temperature, mily, have her sweep and 2- Refusing meds. es- redirect. 1 on 1, referredictivity, return to room, give fluids, change						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМР	(X3) DATE SURVEY COMPLETED 04/13/2011		
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 111 WEST CHURCH AVE SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	* "	•						
	position, adjust room temperature, back rub, call family, leave and try later." The Assistant Director of Nursing provided a Behavior Intervention Detail Report, on 4/13/11 at 8:15 A.M. The report was for behaviors exhibited by Resident # 99 since October 2010. The form indicated from 10/15 to 10/30/10, Resident # 99 had 17 behaviors in which staff attempted 37 interventions with 7 of those being effective, from 11/1 to 11/30/10 Resident # 99 had 38 behaviors in which staff attempted 89 interventions with 8 of those being effective, from 12/2 to 12/31/10 Resident # 99 had 12 behaviors in which staff attempted 24 interventions with 6 of those being effective, from 1/7 to 1/31/11 Resident # 99 had 21 behaviors in which staff attempted 44 interventions with 9 being effective, from 2/1 to 2/15/11 Resident # 99 had 11 behaviors in which staff attempted 21 interventions with 5 being effective, and from 3/2 to 3/19/11 Resident # 99 had 3 behaviors in which staff attempted 3 interventions with no intervention effective. In an interview with the Assistant Director of Nursing, on 4/13/11 at 8:30 A.M., she indicated the care tracker system is where the staff document a resident behavior.							
	She indicated the	e care tracker has a list of						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		LDING	00	COMPI 04/13/2	ETED	
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 111 WEST CHURCH AVE SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLE		
	inappropriate/oth wandering, resist abusive. She indi- member input the a prompt for inte that staff member preprogrammed in the same for each documenting has	iff to choose from socially aer, verbally abusive, as/rejects care, physically acated when a staff as chosen behavior there is rventions attempted by a r. The interventions are into the system and are a behavior but the person at the option to type in any appeted if not in the list of interventions.						